State of Nevada
Division of Mental Health
And Developmental Services
Biennial Report
Fiscal Year 2000

Produced by
Troy Williams
Statewide Program Evaluation Manager

DIVISION ADMINISTRATOR,
CARLOS BRANDENBURG, PH.D.
2001

NEVADA COMMISSION ON
MENTAL HEALTH AND DEVELOPMENTAL SERVICES

FRANCES BROWN, MSN, MDED, RN, CHAIRMAN
DAVID WARD VICE CHAIR

2001 MEMBERSHIP ROSTER

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ERIC C. ALBERS, PH.D.

REPRESENTING REGISTERED NURSES
FRANCES BROWN, MSN, MSED, RN

REPRESENTING PSYCHOLOGISTS
ELIZABETH C. RICHITT, PH. D.

REPRESENTING GENERAL PUBLIC
DAVID WARD

REPRESENTING PHYSICIANS
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REPRESENTING PSYCHIATRISTS
RENA NORA, M.D.

REPRESENTING GENERAL PUBLIC-MH
VACANT

REPRESENTING MARRIAGE AND FAMILY THERAPISTS
JOHN C. BRAILSFORD, PH.D.

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New Beginnings and Upcoming Challenges Characterized Fiscal Year 2000

It is with great pleasure that I present to you the Division of Mental Health and Developmental Services Biannual Report. This report describes the Division's programs, the population we serve and our accomplishments. Our mission can only be accomplished through the continued support and participation of our stakeholders. We acknowledge them and dedicate the new beginnings and program expansions detailed here to them. With their support we accomplish our mission of assisting Nevadans with mental illness or metal retardation to become functional and productive citizens.

Fiscal Year 2000 was characterized by the development of new innovative programs and by increasing consumer demand. Nowhere is this more apparent than with programs such as the new mental health peer counselor program and residential support.

Fiscal Year 2000 has also been a year of new beginnings. Construction was completed on a 12-bed addition at Lakes Crossing Center for the Mentally Disordered Offender which increased the bed capacity from 36 to 48. The State's new psychiatric hospital unit will open in Summer, 2001. The Nevada Mental Health Institute also completed non-structural renovations to their two-inpatient units at the existing hospital.

New community-based mental health programs were initiated to assist those consumers who rely on our outpatient services. All of these community-based programs are intended to reduce the need for hospitalization and foster consumer recovery in the community. Among these programs are:

- Two Programs for Assertive Community Treatment

From the Administrator

(P.A.C.T.) which provide highly specialized services for the most seriously mentally ill residing in the community setting. The goal of the P.A.C.T. programs are to reduce recidivism and assist our clients in maintaining or achieving their maximum level of independence.

- Nevada's first-ever Peer Counselor program began in Jan 2001, providing for the first time, the employment of mental health consumers as staff to help mentor clients and open up our system to their needs.

- An intensive case management program for clients who come into contact with the community justice system and are in need of closer monitoring.

- NMHI consumer classroom offered for the first time brand new computers for consumers in a classroom setting, to let them gain skills so they can return to work.

- A residential treatment program for 8 adult clients with serious mental illness in a short-term, 24-hour residential program at the Nevada Mental Health Institute. Clients in this program are prepared for community living as a transition to more independent community placement. This program serves as an alternative to hospitalization for those clients who may be experiencing difficulties in adjusting to a community placement and need a short-term structured setting prior to reintegration.

- Provided substantial funding increases from FY98 for the prescription of the newer and safer anti depressants and antipsychotic medications.

A new Rural Mental Health Center was opened in Pahrump.

MHDS Division Report

Vision

For all Nevadans with mental illness or mental retardation to realize their optimal potential as individuals and as positive productive citizens of their community and state.

- Homeless programs offered in Mesquite and Pahrump.

- We also started a new mental health program for our senior citizens in Southern Nevada. This program is a collaborative effort between the Division of Mental Health and Developmental Services, the Division of Aging Services and the Bureau of Alcohol and Drug Abuse. The goal of this new program is to improve the mental health service delivery system for elder Nevadans. The target population is older adults who have undiagnosed and untreated illnesses such as depression and alcoholism. This pilot project seeks to impact on the staggering rates of suicide in Nevadans aged 65 and older.

- The Division has completed a comprehensive Division wide MH disaster response plan. This plan has been utilized on at least three separate occasions since the plan was completed. For example, in 1999 the use of this plan resulted in immediate mental health services to Nevadans in emergencies which occurred in Dayton, Reno, and an Alaska Airlines air disaster .

- FY2000 also saw the advancement of MHDS developmental services programs. Accomplishments include:

- The expansion of the definition of DS services to include people with related conditions with diagnosis such as autism, cerebral palsy and epilepsy. This will enable families to receive assistance from MHDS who previously had no services for their relatives.

- In Clark County, the development of 4 new

FROM THE ADMINISTRATOR

ICF/MR Smalls (4 to 6 bed homes) were recruited and developed by Developmental Services to provide community based care for persons in need of extensive support. One of these homes was developed to serve children exclusively.

- Service offices have been added in Winnemucca and Las Vegas. New satellite offices provide better local access for service coordination
- Expansion of Supported Living Arrangements to serve additional individuals in need of moving from ICF/MR programs.
- Full Support for operation of Nevada's Mental Health Advisory Council.
- Expansion of In-Home-Supported-Living-Services to enable families who previously asked for out-of-home placement to keep their relatives at home.

While Fiscal Year 2000 was a year of accomplishment and new beginnings, Fiscal Year 2001-2003 and the future are unfolding as a time for wise planning to meet future challenges. Now, more than ever, the participation of our stakeholders is required to move our programs ahead cost effectively. More than ever, we appreciate your support.

Sincerely,

Carlos Brandenburg
Administrator

DIVISION ADMINISTRATOR, CARLOS BRANDENBURG, PH.D.

MISSION STATEMENT

MHDS: Working in Partnership with its stakeholders:

consumers, families, advocacy groups, agencies and diverse communities.

Mission Statement for the Division of Mental Health and Developmental Services

Working in partnership with consumers, families, advocacy groups, agencies and diverse communities, the Division of Mental Health and Developmental Services provides responsive services and informed leadership to ensure quality outcomes. This mission includes treatment in the least restrictive environment, prevention, education, habilitation and rehabilitation for Nevadans challenged with mental illness or developmental disabilities. These services shall maximize each individuals' degree of independence, functioning and satisfaction.

Division of Mental Health and Developmental Services Overview

The Division of Mental Health and Developmental Services (MHDS) provides services to nearly 24,000 Nevadans each year (20,695 mental health clients and 2,915 Developmental Services clients, total = 23,610 in Fiscal Year 2000). This is an increase of 16.3% from FY 1998. In addition to these direct consumers, the Division works with many stakeholders, including family members, advocates, service providers, legislators, the general public ,and law enforcement. As a result of these diverse interests, the issues facing the Division in addition to being complex, are also viewed from many different perspectives. The underlying thread of unity in this diverse system, however, is the commitment of all stakeholders to a public mental health/developmental services system that meets the needs of Nevada's citizens.

DIVISION OVERVIEW

Provide comprehensive, state of the art, cost efficient and high quality services which are accessible, available, and responsive to the needs of individuals, families and communities, emphasizing community based services.

The Division of MHDS is responsible for the operation of state funded community mental health programs, psychiatric inpatient programs, mental health forensic services and all developmental services programs and facilities. By statute the Division is responsible for planning, administration, policy setting, monitoring and budget development of all state funded mental health and developmental services programs. The Division Administration is also directly involved in decisions regarding agency structure, staffing, program and budget development. The mission of the Division is to develop and operate programs which assist individuals who have mental illness or developmental disabilities to live as independently as possible. The Division is obliged to offer care regardless of ability to pay, assure services are offered in the "least restrictive environment," base services upon individual needs, and honor client's rights. The Division is committed to providing cost effective services that ensure consumer and citizen safety, are readily accessible to all persons in need, are responsive to local needs, are consumer-driven and promote self-sufficiency.

The MHDS Division is located within the Department of Human Resources. The Division Administrator, appointed by the Governor, relies on the oversight and direction of stakeholders as represented in several advisory groups. A Commission on Mental Health and Developmental Services is appointed by the Governor and "establishes policies to ensure adequate development and administration of services for the mentally ill, mentally retarded and related conditions…" The Commission has several powers related to the oversight of programs within the Division. Local Advisory Boards exist within each region by authority of the Commission and are involved with local agency issues. Administration and services are organized into three regions: North, South and Rural.

Mental Health:

Four agencies deliver mental health care in the state. In the Reno area the Nevada Mental Health Institute (NMHI) is an inpatient psychiatric hospital that also provides a variety of outpatient community based services. The same campus also houses the Lakes Crossing Center, the State's facility for mentally disordered criminal offenders. Rural Clinics is responsible for operating a network of community mental health centers in the 15 rural counties of the state. Las Vegas houses a psychiatric inpatient unit: Southern Nevada Adult Mental Health Services (SNAMHS) plus outpatient community based services provided through four community mental health centers.

The Division actual expenditures for Fiscal Year 2000 was $60,984,483 with 747 positions (FTE) funded. This is an increase of 9.2% over the Fiscal Year 1999 actual expenditures of $55,843,760 It is also an increase of 37 new positions.

A full range of adult mental health services are provided by the Division which are categorized into seven specific programs: Outpatient Counseling, Case Management, Medication Clinic, Psychosocial Rehabilitation, Housing, Residential Treatment Programs (RTP) and Program for Assertive Community Treatment (PACT). In State Fiscal Year 2000, 20,695 individuals received mental health services, an increase of 5% over the 19,711 served in Fiscal Year 1999.

MHDS OVERVIEW

Center for the Mentally Disordered Offender

LAKE'S CROSSING

Mental Health Institute

NORTHERN NEVADA

Community Outpatient Services

RURAL CLINICS

Adult Mental Health Services

SOUTHERN NEVADA

Create a seamless and coordinated service system among all the agencies which collaborate on meeting the needs of people in the public sector with mental illness and/or developmental disabilities.

Since 1997, youth services have been incorporated into a separate Division of Child and Family Services within the Department of Human Resources. DCFS administers family support services, child care licensing, juvenile justice and an array of treatment services for youth in the urban areas of Clark and Washoe counties. However, in the remaining 15 rural counties, these youth services are offered via the Mental Health Division's system of rural clinics.

Since 1998, the mental health service priority within the Division has been consumers with serious mental illness. The Division in FY 97 revised the Nevada Administrative Code (NAC) to expand the state definition of seriously mentally ill. The definition for serious mental illness in the Nevada Administrative Code (NAC) reads:

> " Adults with a serious mental illness are persons 18 years of age and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder that meets DSM criteria (excluding the substance abuse or addictive disorders, irreversible dementias as well as mental retardation) which has resulted in functional impairment which subsequently interferes with or limits one or more major life activities.
>
> 'Functional Impairment' addresses the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health - illness and is viewed from the individual's perspective within his environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety."

The Nevada Alliance for the Mentally Ill (NAMI) is active in each region and has representation at most local advisory board meetings and the meetings of the Commission on Mental Health and Developmental Services . The Mental Health Planning Advisory Council, which is a 17 member council (51% must be consumers of Mental Health), works with the Division on a number of levels by providing input on the State's Mental Health Plan.

Developmental Services

Three regional centers provide services for people with developmental disabilities and related conditions throughout Nevada. In the Las Vegas area, Desert Regional Center offers community-based services in it's main office and three branch offices in Henderson, Pahrump and North Las Vegas. The largest state–run residential treatment program is located on the campus near the main office. In the Reno area, Sierra Regional Center provides community-based ser-

vices and is the location of the other state-run residential treatment program in the state. Rural Regional Center, located in Carson City with satellite offices in Elko, Fallon and Winnemucca, offers community-based services for the rural Nevada counties.

These facilities provide a full range of services for people with developmental disabilities and related conditions and their families that include: Service Coordination, Family Support (respite, financial and other assistance), Jobs and Day Training, Residential Programs, and Quality Assurance. In Fiscal Year 2000, these programs served 2915 individuals.

The service vision for the Division's developmental services programs, Developmental Services Vision for the year 2000, was developed based on stakeholder input in 1997. This vision updated and broadened service goals within the context of state and federal legislative intent to assist individuals with severe or profound mental illness:

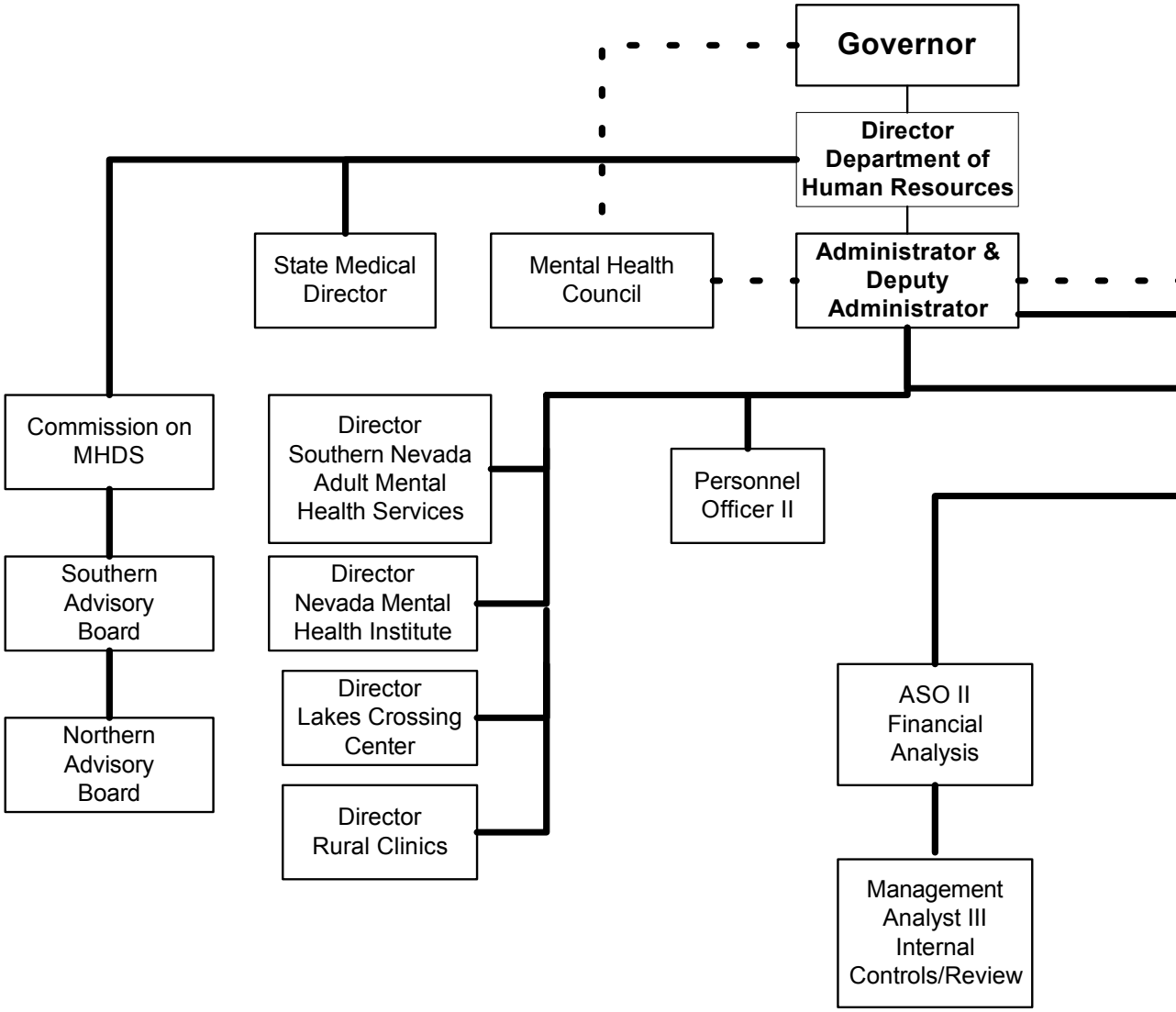
- Develop physical, intellectual, social and emotional capabilities to the fullest extent;
- Live in an environment that is conducive to personal dignity
- Continue development of those skills, habits and attitudes essential to adaptation in contemporary society.

The Division is also mandated 'to assure that individuals with developmental disabilities and their families have access to culturally competent services, supports and other assistance and opportunities that promote independence, productivity, and integration and inclusion into the community (The Developmental Disabilities Assistance and Bill of Rights Act Amendments of 2000).'

The service priority within the Division for developmental services has been to increase community-based living and work options and to reduce the need for people with developmental disabilities to be admitted to state institutions and congregate living facilities. To this end, the legislature approved in FY 1998 the phase-in of additional resources to assist family members with significant disabilities to remain at home (Family Support), to increase individualized community living supports for adults (Supported Living Arrangements; SLAs), and to provide community job options.

The number of people living in large state institutional centers has been stable over several years. This is due to the growth of private and public ICF/MR Smalls (community residences with up to 6 persons in residence). Supported Living Arrangements (SLAs) comprise nearly 80% of all community placements and provide individualized services in homes and apartments for 1-4 people in each living setting. Group homes and developmental homes ranging from 4 to 6 residents per home comprise the rest. Reducing the size of living situations has been part of a statewide effort to provide the least restrictive living situation possible. (For discussions of FY 2000 funding and expenditures in these programs see Developmental Services Funding Sources on page 47).

ORGANIZATIONAL CHART



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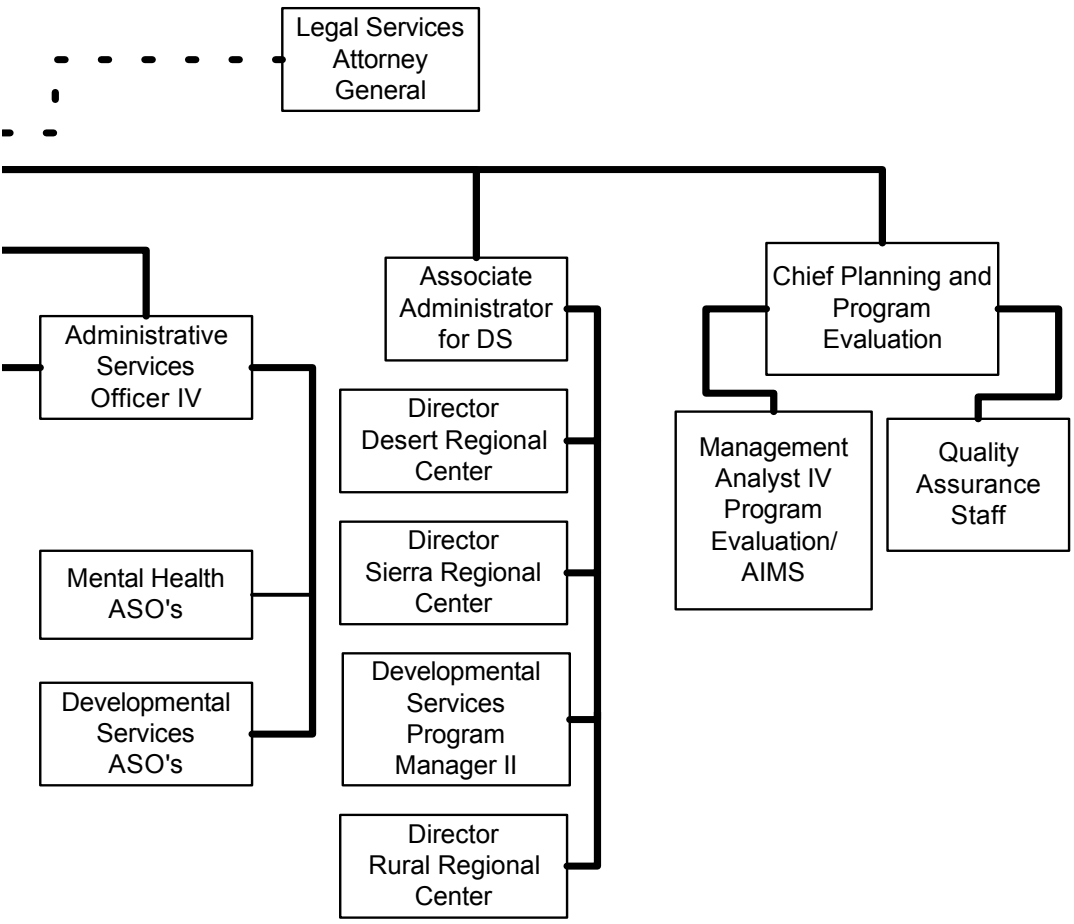

Foster an environment which treats employees fairly with dignity and respect, empowers employees to be involved in the functioning of the Division and agency and encourage a work environment which values innovation, team efforts, professional development and improvement of work process.

LOCATIONS OF SERVICE

MENTAL HEALTH & DEVELOPMENTAL SERVICES (MHDS)
505 East King Street, Room 602
Carson City, Nevada 89701-3790
Telephone (775) 684-5943
Faxes (775) 687-5966 & 687-5964
E-Mail: mhds@govmail.state.nv.us
Carlos Brandenburg, Ph.D., Administrator
Debbie Hosselkus, LSW, Deputy Administrator

David Rosin M.D., State Medical Director

SIERRA REGIONAL CENTER (SRC)
Family Support Programs
605 South 21st Street
Sparks, Nevada 89431-5599
Telephone (775) 688-1930
Fax (775) 688-1947
Dave Luke, Ph.D., Associate Administrator
For Developmental Services

DESERT REGIONAL CENTER (DRC)

1391 South Jones Boulevard
Las Vegas, Nevada 89146-1200
Telephone (702) 486-6200
Fax (702) 486-6334
Stan Dodd, LCSW, Clinic Director

RURAL REGIONAL CENTER (RRC)
625 Fairview Street, Suite 120
Carson City, Nevada 89701-5430
Telephone (775) 687-5162
Fax (775) 687-1001
Marcia Bennett, Ph.D., Clinic Director

RRC Elko Office
850 Elm Street
Elko, NV 89801
Telephone (775) 753-1100
Fax: (775) 753-1131
Debbie Harris, Develop. Disabilities
Specialist

LAKES CROSSING CENTER FOR THE MENTALLY DISORDERED OFFENDER
500 Galletti Way
Sparks, Nevada 89431-5573
Telephone (775) 688-1900
Fax (775) 688-1909
Elizabeth Neighbors, Ph.D., Director

NEVADA MENTAL HEALTH INSTITUTE
480 Galletti Way
Sparks, Nevada 89431-5573
Telephone (775) 688-2001
Fax (775) 688-2052
Harold Cook, Ph.D., Clinic Director

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES (SNAMHS)
6161 West Charleston Boulevard
Las Vegas, Nevada 89146-1126
Telephone (702) 486-6000
Fax (702) 486-6248
James Northrop, Ph.D., Clinic Director

SNAMHS - Henderson Office
98 East Lake Mead Drive
Henderson, Nevada 89015
Telephone (702) 486-6700
Fax (702) 486-6708

SNAMHS - North Las Vegas Office
2121 North Las Vegas Boulevard
North Las Vegas, Nevada 89030
Telephone (702) 486-5750
Fax (702) 486-5769

SNAMHS - Southeast Office
1820 East Sahara Avenue,
Suite 109
Las Vegas, Nevada 89104-3736
Telephone (702) 486-8289
Fax (702) 486-8295

SERVICE LOCATIONS

RURAL CLINICS: Administrative Office
503 North Division St.
Carson City, NV 89703-4104
Telephone (775) 687-1000; Fax (775) 687-3544
Larry Buel, Ph.D., Clinic Director

CLINICS:

Battle Mountain Mental Health Center
101 Carson Road, Suite #1/P.O. Box 50
Battle Mountain, NV 89820-0050
(775) 635-5753; (775) 635-8028 Fax
Phyllis Herda-Hipps, LCSW

Carson Mental Health Center
1330 South Curry Street
Carson City, NV 89703-5202
(775) 687-4195; (775) 687-5103 Fax
Marilyn Newell, Clinic Director

Dayton Mental Health Center
120 Pike Street/P.O. Box 1597
Dayton, NV 89403-1597
(775) 246-5240; (775) 246-5364 Fax
Jim Diss, Psy. D., Clinic Director

Douglas Mental Health Center
1422 Mission Street, Gardnerville, NV 89401-5239
(P.O.Box 1509, Minden, NV 89423)
(775) 782-3671; (775) 782-6639 Fax
Tom Embree, Clinic Director

Elko Mental Health Center
1515 7th Street
Elko, NV 89801-2558
(775) 738-8021; (775) 738-8842 Fax
Charles Voigt, LCSW, Clinic Director

Ely Mental Health Center
1595 Avenue F/P.O. Box 187
Ely, NV 89301-0187
(775) 289-1671; (775) 289-1699 Fax
John Fowler, LCSW, Clinic Director

Fallon Mental Health Center
151 North Main Street
Fallon, NV 89406-2909
(775) 423-7141; (775) 423-4020 Fax
Laura Wendlandt, Ph.D., Clinic Director

Fernley Mental Health Center
115 West Main Street/P.O. Box 2314
Fernley, NV 89408-2314
(775) 575-0670; (775) 575-0672 Fax
Jim Diss, Psy.D., Clinic Director

Hawthorne Mental Health Center
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Hawthorne, NV 89415-0012
(775) 945-3387; (775) 945-2307 Fax
Laura Wendlandt, Ph.D., Clinic Director

Lovelock Mental Health Center
775 Cornell Ave. Suite #C/P.O. Box 1046
Lovelock, NV 89419-1046
(775) 273-1036; (775) 273-1109 Fax
Sharon Maginnis, LASW, MH Counselor II

Mesquite Mental Health Center
416 Riverside Road/P.O. Box 3567
Mesquite, NV 89024
(702) 346-4696; (702) 346-4699 Fax
John Welsh, MA, Clinic Director

Pahrump Mental Health Center
1840 South Pahrump Valley Blvd. Suite A
Pahrump, NV 89048
(775) 751-7406; (775) 751-7409 Fax
Jim Polk, L.C.S.W., Clinic Director

Silver Springs Mental Health Center
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Springs, NV 89429-1136
(775) 577-0319; (775) 577-9571 Fax
Jim Diss, Psy.D., Clinic Director

Tonopah Mental Health Center
119 St. Patrick Street/P.O. Box 494
Tonopah, NV 89049-0494
(775) 482-6742 & 482-9819 Emergency
(775) 482-3718 Fax; Bruce Allen,
Vacant, Clinic Director

Winnemucca Mental Health Center
460 Haskell Street/P.O. Box 230
Winnemucca, NV 89446-0230
(775) 623-6580; (775) 623-6584 Fax
Phyllis Herda-Hipps, LCSW, Clinic Director

Yerington Mental Health Center
310 Surprise Avenue
Yerington, NV 89447-2542
(775) 463-3191; (775) 463-4641 Fax
Jim Diss, Psy.D., Clinic Director

STAKEHOLDERS

Establish partnerships among stakeholders as to the direction of public mental health and developmental services in the state.

Stakeholder Values

Community Integration:
Clients contribute to the community through positive behavior.

Consumer Involvement:
Clients are educated about their disorders and actively involved in their treatment.

Consumer Satisfaction:
Clients feel good about the kinds of services received.

Family Support:
Clients' families are informed and involved.

Safety:
Client's and the community are safe from the client's behavior.

MHDS-MENTAL HEALTH SERVICES:

Involving Stakeholders in Planning and Evaluation

MHDS directly involves its stakeholders in the planning and quality improvement of its mental health programs . Consumers, family members, legislators, and mental health professionals as well as representatives from the courts, and correctional fields have been formally involved in the definition of values that underlie the mission of the Division and guide the strategic planning of the mental health programs. The general community is also invited to participate in strategic planning meetings, and has been instrumental in defining the mission statements of the agencies. These stakeholders are updated on the progress made toward the goals and objectives.

Stakeholders also participate in major decision making committees. A task force of stakeholders has guided the development of meaningful outcome measures for the evaluation of MHDS' mental health programs. Stakeholders are also appointed by the Governor to the Mental Health Planning Council. The Council helps steer the direction of the MH agencies and the Division's utilization of Federal Block Grant funds. Community participants in this group are involved in collaborative planning efforts along with representatives from other public agencies that have contact with MHDS' consumers (Education, Vocational Rehabilitation, Bureau of Alcohol and Drug Abuse, Welfare, Division of Child and Family Services).

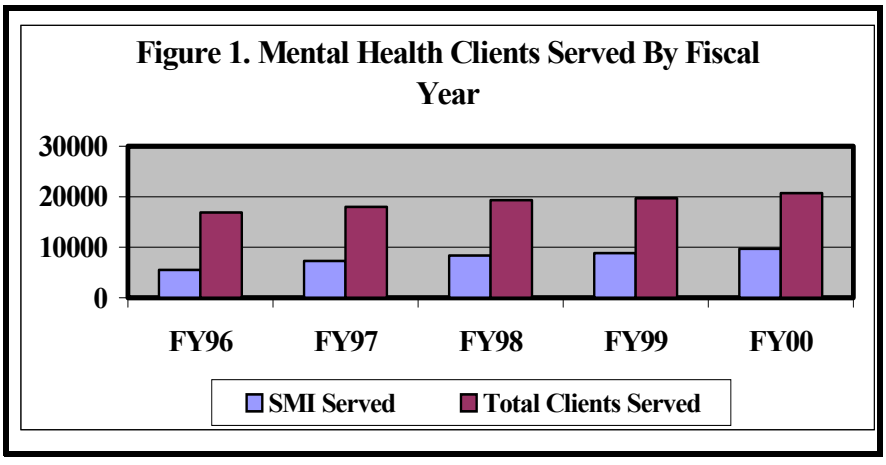
Southern Nevada Adult Mental Health Services and the Nevada Mental Health Institute employ Peer Counselors to help in the quality assurance process as well as consumer advocacy. Included among Peer Counselor activities are attendance at stakeholders meetings, participation in quality assurance efforts, attendance at various agency committee meetings and patient education.

Consumer volunteers have also been involved in establishing consumer oriented outcome measures for the evaluation of how well MHDS' mental health programs accomplish their goals. Some volunteers have also worked in data collection, data survey efforts and program evaluation.

Who are the Recipients of Mental Health Services?

The Division of Mental Health and Developmental Services directly provides or coordinates the provision of contracted adult public mental health services in Nevada. MHDS's Rural Clinics also provide services to children and families. A single University affiliated provider, Mojave Mental Health in Las Vegas, provides much of the regions outpatient services through referral from SNAMHS. Inpatient and outpatient programs are provided primarily on a fee for service basis since people with serious mental illness have been "carved out" of the State's managed care structure.

The Center for Mental Health Services[1] estimates that 7.2% of the population in Nevada will suffer from a severe mental illness during their life. More recently, a study [2] ranked Nevada as the number one state in the Western United States for prevalence of mental illness, estimating that as much as 23.7% of the population in Nevada will have some form of diagnosable mental disorder during their life. It also estimated that approximately 1.8% of Nevadans are currently dysfunctional because of a serious mental illness. In FY 2000, the Division's mental health programs served 20,695 people. This is an increase of 5% over last year. Rural services were extended in FY 1999 with the opening of 2 new clinics, Pahrump and Mesquite. **Figure 1** and **Table 1** show growth in individuals served over the last five fiscal years. **Figure 2** shows percent of clients by agency.



1 *Estimation of the 12-Month Prevalence of Serious Mental Illness*, CMHS Draft, Kessler, et al. 1997.
2 *Needs Assessment in the West: a Report on a Workshop and Subsequent Analysis* (WSDSG, 1998)

CONSUMERS

Establish and maintain an environment which fosters dignity and respect for clients and family.

Stakeholder Values

Improved Social Functioning:
Clients make progress in work, school and relationships.

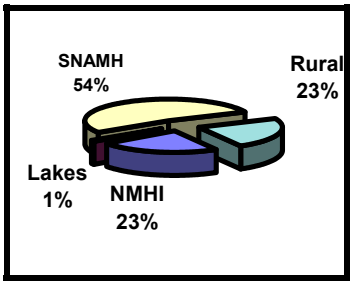
Personhood:
Clients have worth and dignity.

Skilled Coping:
Clients gain skills needed to handle the problems of life.

Symptom Reduction:
Clients symptoms are reduced, stabilized or prevented.

Mental Health Clients

Figure 2. Percent of Total Clients Served by Agency



Mental Health Institute
NORTHERN NEVADA

Center for the Mentally Disordered Offender
LAKE'S CROSSING

Community Outpatient Services
RURAL CLINICS

Adult Mental Health Services
SOUTHERN NEVADA

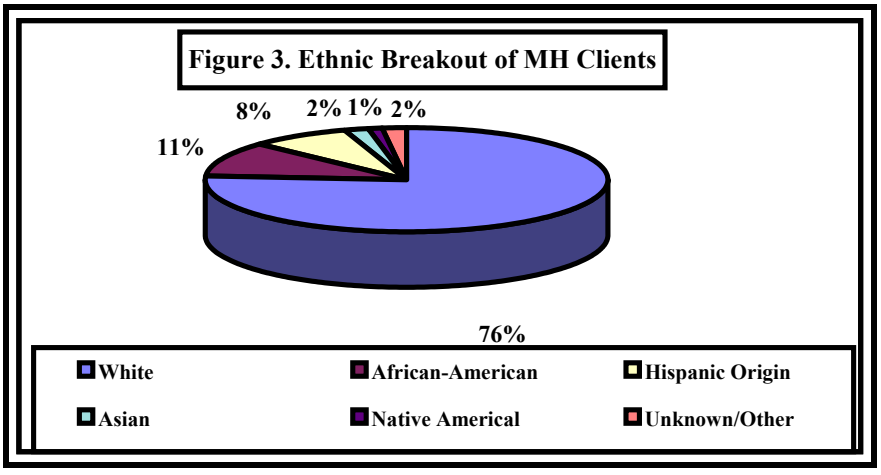
Table 1. Unduplicated Clients Served: Percent Growth

	FY99	FY00	%change
Lakes	190	193	1%
NMHI	2680	3284	22%
SNAMHS	10480	11051	5%
Rural Clinics	5173	4928	-5%
TOTAL	18523	19456	5%

For the most part, the people served by the public mental health system are a direct reflection of Nevada's demography. With the exception of MHDS' forensic facility, both the state demography and MHDS' clients are an equal split between male and female individuals. Around 72 percent of the clients served by SNAMHS and 47% of the Rural Clinics are between 21 and 44 years of age. MHDS only serves children at its Rural Clinics, where they comprise around 26% of the client base. This is similar to the demographers estimate for the percentage of children in the state at 25.3%.

Approximately one third of the clients have never married, and most claim only themselves as a single dependent. More than one third are unemployed and not looking for work.

Around 76% of MHDS' consumers are white in comparison to 70.3% of Nevada's population. **Figure 3**, details MHDS' breakout of clients by ethnicity. The largest category of racial minorities served at Nevada's urban mental health centers are African Americans. In contrast, Native Americans are the primary racial minority in MHDS's



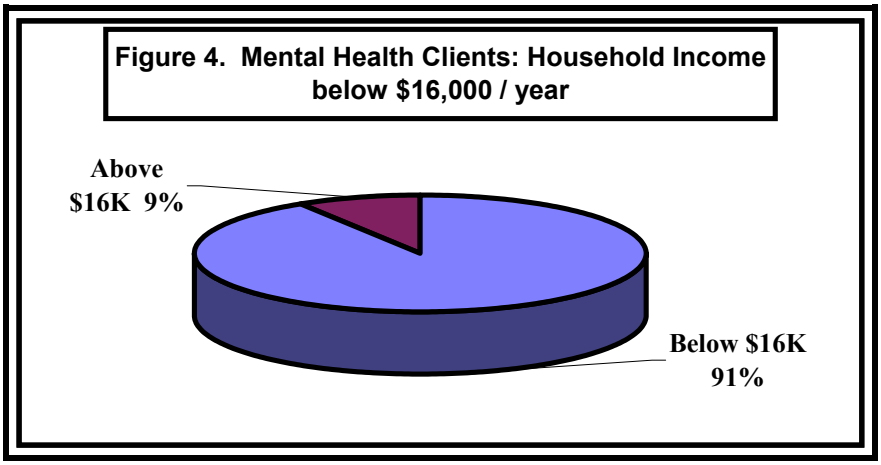
The State's 2000 figures are projections. Note, although included, Hispanics are an ethnicity, not a race. MHDS Rural data included in breakout comparison.

rural mental health clinics. Ethnically, approximately 8% of the State's public mental health consumers are Hispanic. The state demographer estimates that Hispanics will comprise around 13% of Nevada's population by 2003.

It is estimated that in 2000, 10.3% of all Nevadans lived below the poverty level. This contrasts sharply with the consumers of Nevada's public mental health services. As a rule, the people who come for mental health service are from lower income brackets, with approximately 91% of MHDS' consumers being below the $16,000 per year. **Figure 4** shows percent of clients below $16,000 in income.

Generally, people come to MHDS' locations for treatment of a few primary disorders: major depression, psychosis, bipolar or schizophrenic episodes. Outpatient clients show a wider range of

Note: This data excludes the unknown category



treatment needs. Seventy three percent of outpatient clients fall into several categories: adjustment disorders, mood disorders, major depression, dysthymia, and schizophrenia. Around 10% of our outpatient consumers have a dual diagnosis, suffering from both mental illness and substance abuse.

Children served by the Division's Rural Clinics primarily sought service in FY 00 for help with depression (10.8%), attention deficit (33%), bipolar (3.3%) adjustment disorder (31.8%), and anxiety (6.9%).

3. Division Demographics are based on a four year data analysis – FY 1994 to 1997 data).

MENTAL HEALTH SERVICES

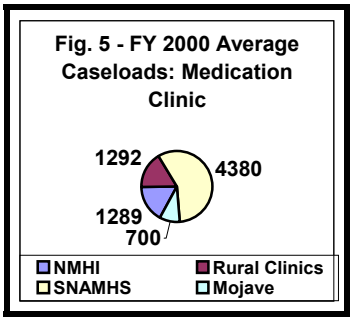
Top Outpatient Diagnosis at Admission

Mood Disorders	**49%**
Schizophrenia and related	**17%**
Substance Related Disorders	**10%**
Adjustment & Personality Disorders	**7%**
Other Disorders	**20%**

Top Inpatient Diagnosis at Admission

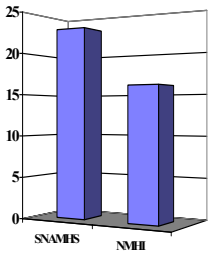
Schizophrenia and related	**43%**
Mood Disorders	**35%**
Substance Related Disorders	**10%**
Adjustment & Personality Disorders	**7%**
Other Disorders	**5%**

MEDICAL SERVICES



INPATIENT SERVICES

Figure 7 - Average Length of Stay in Days (FY 2000)

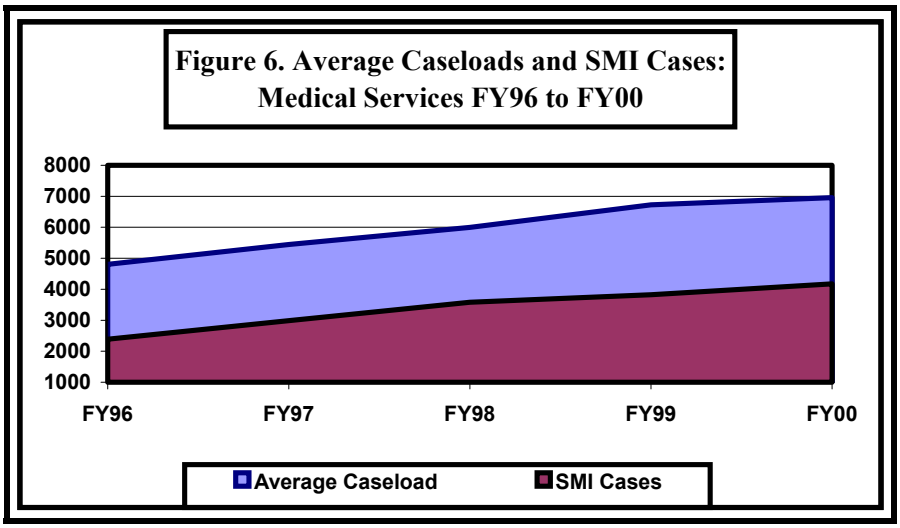


MENTAL HEALTH PROGRAMS

Several levels of mental health care are provided through inpatient and outpatient programs. Clients requiring intensive care are supported by inpatient services and intensive outpatient programs. Other outpatient programs help the client gain greater independence, confidence and ability to function in the community.

The Role of New Medications: The Division's medical services are provided by a physician or advanced practice nurse with prescriptive privileges to evaluate, prescribe and monitor medications for the treatment of psychiatric disorders. Services may also include pharmaceutical counseling and education provided by a pharmacist. Since medication forms a foundation of treating most mental illnesses, the medication clinic is the Division's largest treatment program (**Figure 5** shows the medical services clients served by agency. **Figure 6** shows program growth).

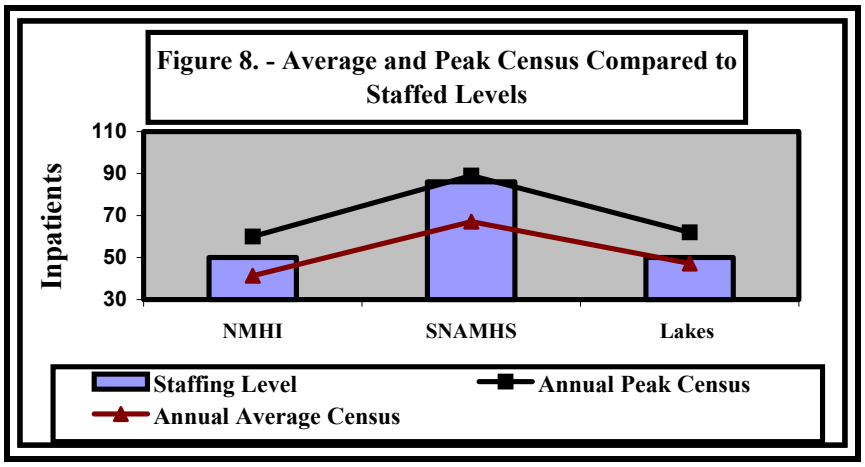
Newer antidepressant and anti-psychotic medications have had fewer negative side effects than older medications. While they cost more, they benefit client functioning and reduce the demand and duration of other expensive treatment forms.



Inpatient Programs:

Inpatient facilities at the Nevada Mental Health Institute and Southern Nevada Adult Mental Health Services focus on consumer recovery and stabilization. At SNAMHS, individuals in crisis are served by a ***Psychiatric Emergency Services*** (PES) unit which has a capacity for 10 patients. The provision of emergency psychiatric services allows clients in crisis to be stabilized and avoid admission to the hospital. The positive effect of this program is shown by the fact that

more than 83% of the clients admitted to the PES are stabilized and avoid hospitalization. **Figure 7** (previous page – sidebar) compares the average length of stay between SNAMHS (with a PES) and NMHI (without a PES). An NMHI Psychiatric Emergency Services (PES) opened in January 2000. **Figure 8** compares the average census and peak census for each of the mental health inpatient facilities in Fiscal Year 2000. **Figure 9** shows the portion of inpatient clients served at each of the hospitals.



Forensic Services: Lakes Crossing Center was designed to serve the mentally disordered criminal offender, to evaluate competency to stand trial, assess criminal responsibility and/or provide recommendations for treatment. Services include clinical assessment, forensic evaluation and short or long term treatment as appropriate based on the nature of the court commitment. Ninety seven percent (97%) of the clients are sent to the Center by the courts for treatment to establish competency to stand trial or for initial competency evaluations (see **Figure 10** – sidebar). This relationship between this agency and the court and legal system is defined in NRS Chapter 178.

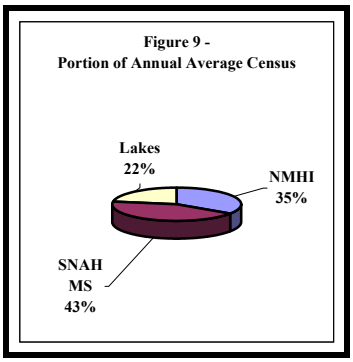
The 48 bed Center served 203 clients in Fiscal Year 2000. Eighty seven percent (87%) of all admitted clients in FY 2000 were Nevada residents; Thirteen percent (13%) were from California and other states. Most of the state admissions come from urban areas (12% north, 65% south) with only 23% admitted from rural Nevada. As an average in FY 2000, client length of stay is 112 days. During Fiscal Year 2000, the census peaked above facility capacity four months out of the year. The highest peak was 23% above capacity.

Outpatient Programs with an Intensive Care Focus:

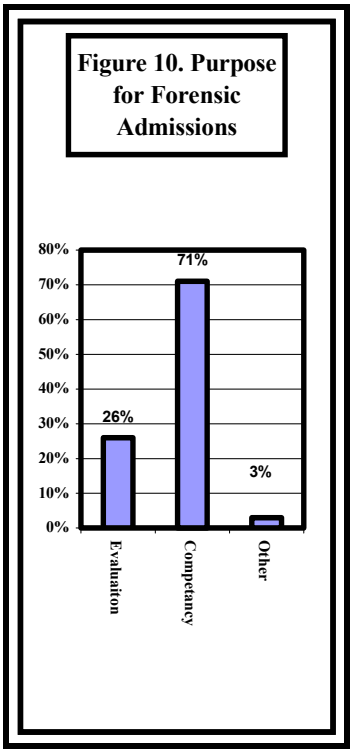
Program for Assertive Community Treatment (PACT): This program provides intensive community based treatment and rehabilitation services to clients with serious mental illness by using a multidisciplinary mental health team to provide these services. The goal of the program is to reduce debilitating symptoms and minimize

MENTAL HEALTH SERVICES

INPATIENT SERVICES



FORENSIC SERVICES



PACT

The Program for Assertive Community Treatment uses a multidisciplinary mental health team to provide customized mental health services.

RTP

As an alternative to hospitalization, the Residential Treatment Program focuses on increasing independent living skills

or prevent recurrent acute episodes of illness. Continuous rather than time limited service and interventions tailored to each consumer characterize this program. Nationally, the PACT model has shown participants to have longer and more productive community tenure and be better able to manage their impairment upon discharge from the program.

This program started serving clients at Southern Nevada Adult Mental Health Services campus in March 1998. The program is budgeted for a caseload of 74 individuals in Fiscal Year 2000 and has been undergoing planned growth of around 5 new clients per month. At the end of Fiscal Year 1998 the program was serving 23 consumers. Nevada Mental Health Institute began this program in Fiscal Year 1999.

Residential Treatment Program (RTP): This program provides treatment and psychosocial rehabilitation for patients who may be having difficulty in adjusting to a community placement and need a short-term structured setting prior to reintegration. As an alternative to hospitalization, the program focuses on increasing independent living skills and reduced hospitalization for clients who are frequent, repetitive users of inpatient care. Contract and MHDS staff work with the client in planning to re-enter the community. Participants have access to all outpatient programs that assist in developing daily living skills, improvement of socialization abilities, and pre-vocational training as well as education concerning medication management.

This intensive care program is budgeted for 8 adult patients at NMHI and 10 patients at SNAMHS. While program planning and development were underway in Fiscal Year 1998, clients did not participate in the program until Fiscal year 1999.

Intensive Case Management: Intensive case management provides more intensive care for forensic clients in Southern Nevada. It provides a linkage to other community based services for clients in the programs that utilize emergency services. Additionally, traditional case management services such as medication management, financial management and residential services are provided on a more frequent and structured basis. The program began serving clients at SNAMHS in December 1997. Since that time, the average monthly caseload has more than quadrupled, growing from 11 initial clients to 47 clients at the end of Fiscal Year 2000. The program is budgeted to support a caseload of 45 people.

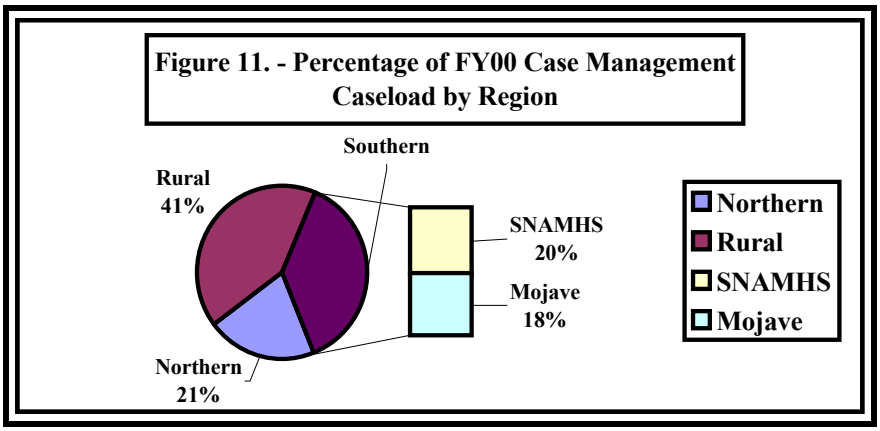
Outpatient programs focusing on increasing consumer independence:

Personal Service Coordination (Case Management): Case managers coordinate treatment and assist individuals in accessing services and choosing service opportunities based on a treatment plan developed with the client. They assure that clients access financial, housing, medical, employment, social, transportation, crisis intervention, entitlement and other essential community resources. They also help mobilize family, community, and self-help groups on the client's behalf. They may provide direct treatment to clients when none is

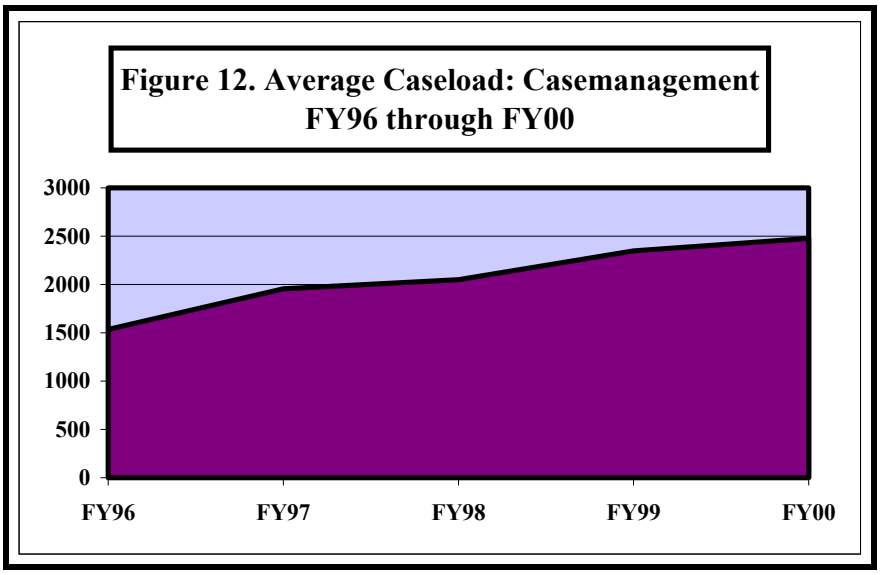
Personal Service Coordination

available through referrals or community agencies.

MHDS' Personal Service Coordination caseload averaged around 624 cases at NMHI, 1254 cases in Rural Nevada and 598 cases in Southern Nevada. Additionally, Mojave Mental Health (University affiliated provider under contract to MHDS) served an average monthly caseload of 556 people. (**Figure 11** shows case management case distribution, **Figure 12** – growth in caseload over last five years).[4]



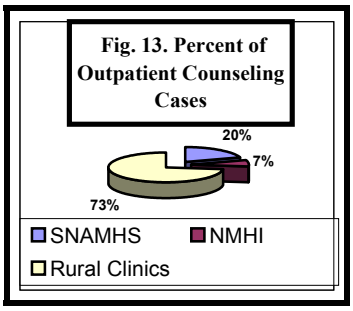
4 This does not include clients at Mojave Mental Health



Outpatient Counseling: Outpatient counseling services provided to individuals include diagnosis and evaluation, counseling, psychotherapy, and behavioral management. These programs focus on developing insight, producing cognitive/behavioral change, improving decision-making, and/or reducing stress. Specialized services are provided to families and couples to facilitate communication between

OUTPATIENT SERVICES

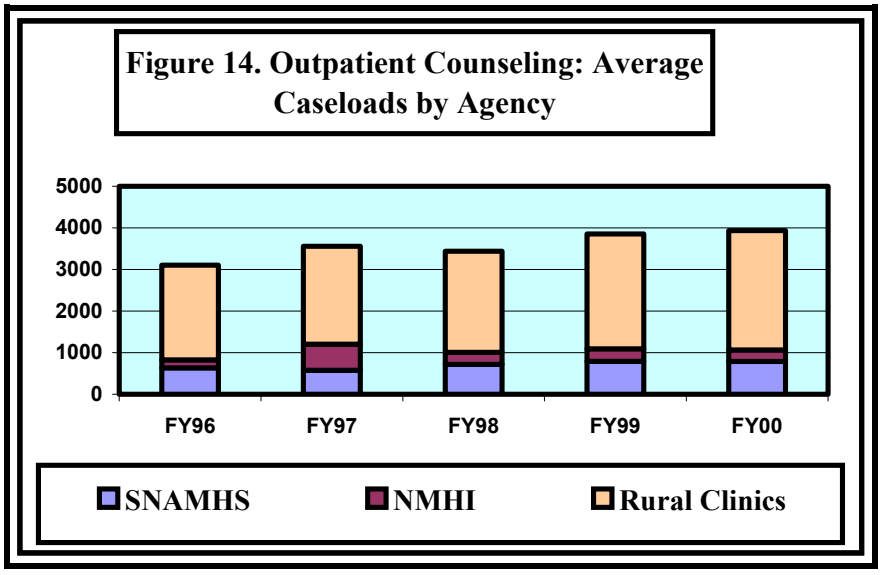
Outpatient Counseling



patients and family members. Group counseling sessions include activity therapy as well as psychotherapy to help guide patients through interpersonal conflict and improve positive communication. Outpatient Counseling, Rural Clinics primary program, serves as the foundation program for all of its clients. NMHI and SNAMHS may admit patients into other programs, such as case management, without first seeing a counselor.

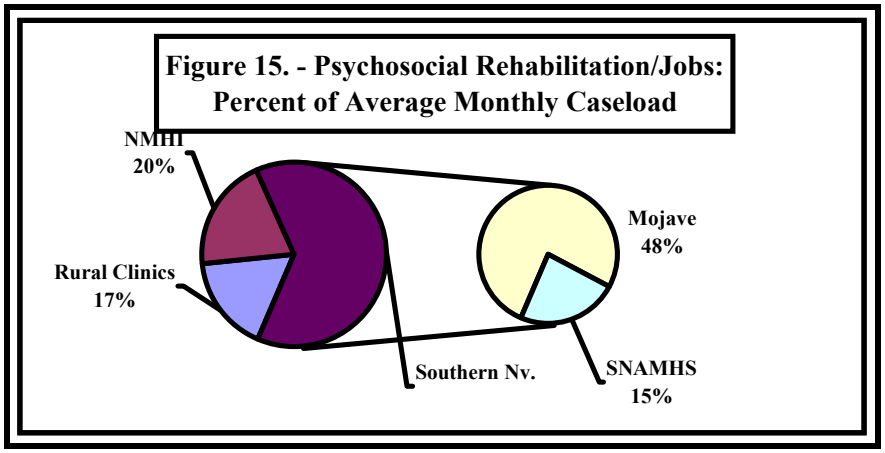
Figure 13-(side-bar) shows the portion of outpatient counseling clients served by agency.

Figure 14 shows 5 years of counseling caseloads.



Psychosocial Rehabilitation and Vocational Programs:

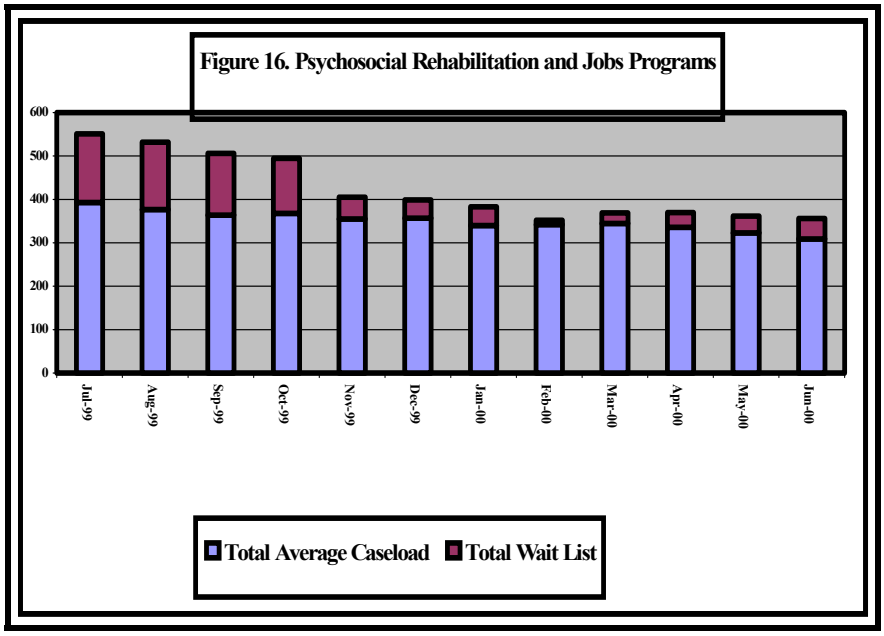
Psychosocial rehabilitation is targeted to clients in need of an



active treatment environment to foster their independence in the community. The goal is to maximize an individual's level of functioning in the community and to prevent acute inpatient care. Emphasis is placed on acquiring skills in the following areas: survival and adaptation, symptom and medication management, problem solving, grooming, financial management, prevocational services, and management of leisure time. Programs are individualized for the consumers. Some services are provided under contract and may take place in a classroom setting or at the client's residence. **Figure 15** (previous page) shows each agency's portion of the psychosocial rehabilitation caseload.

Figure 16 shows program caseload and wait list during Fiscal Year 2000.

Peer advocates, themselves prior consumers of the mental health system, receive training in work skills, advocacy, and empowerment, and life management. They then put this education to use in a peer advocacy internship. They provide a voice for people in the mental health system. They are encouraged to participate in community advocacy and support groups to help foster their integration into the community.



Vocational programs include vocational guidance and counseling, and transitional planning. They also provide an array of skills training through school, peer advocacy, world of work classes through BVR and on the job training and apprenticeships. This program assists with job seeking skills and provides support during job seeking as well as thru BVR. Clients are assisted through vocational assessment, work adjustment training and post-employment services designed to maintain employment by focusing on decision making, problem solving and establishing natural community supports. Additionally, joint efforts between MHDS and the State's Bureau of Vocational Rehabilitation (BVR) provide collaborative assistance to help clients achieve their vocational goals.

OUTPATIENT SERVICES

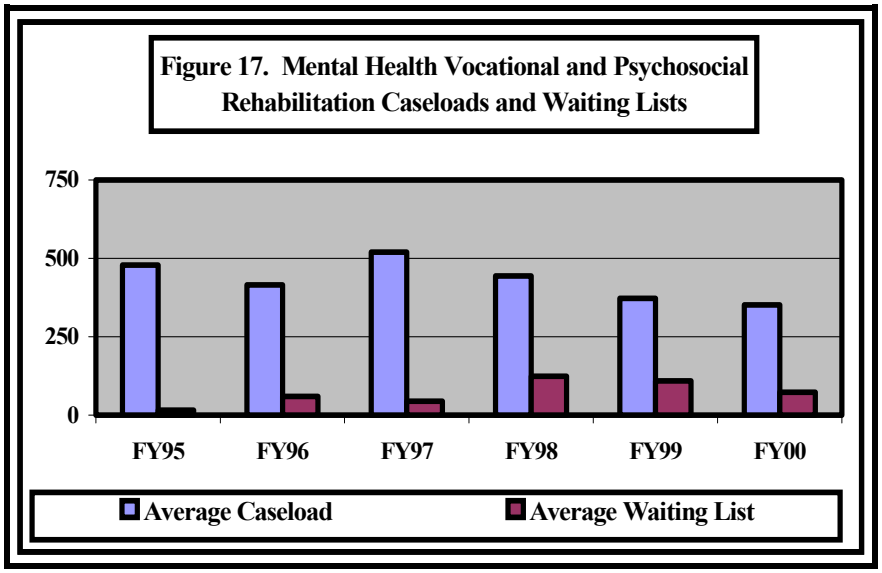
Psychosocial Rehabilitation And Jobs

Peer counselors, themselves prior consumers of the mental health system, work with clients in these programs by providing education, advocacy, and support.

OUTPATIENT SERVICES

Helping people find employment through vocational assistance and training

These programs are in demand by consumers as can be seen by their waiting lists for services (**Figure 17**). The Divisional annual average caseload (Vocational and Psychosocial Rehabilitation programs combined) in Fiscal Year 2000 was at 351 clients . SNAMHS Psychosocial Rehabilitation Program placed an average of



81% of its clients in its developmental job program over the last 15 months.

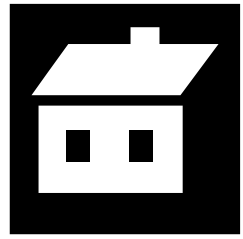
Residential Supports:

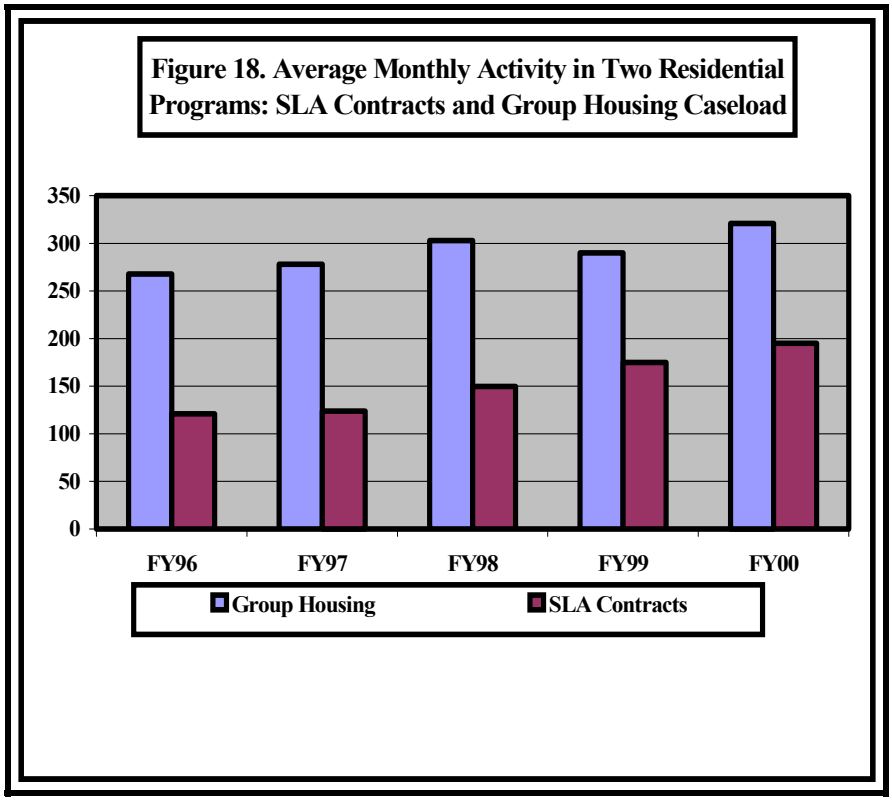
Group housing: These are group residential programs for clients who do not require specialized intensive services. The Division average annual caseload is approximately 321 clients (see **Figure 18** (following page).

Supported Living Arrangements (SLAs): These living arrangements are intended to be flexible and offer housing based on client choice and individualized services tailored to the client's needs so that services have a "wrap around" effect and encompass the capabilities of the client. Clients, families and agencies collaborate in the development of a plan that will place the client in an independent setting. The program includes purchased community SLA's, contract services and the **HUD Shelter Plus Care Program** for homeless mentally ill people. **Figure 18** compares the five year average group housing caseloads to the average number of SLA contracts.

Respite Care: This service is for those clients already enrolled in Community Outpatient Services. The client must be in crisis but not eligible for inpatient hospitalization and must need to be removed from the living situation for a short duration, (not to exceed 5 days). The purpose is to provide supervision and psychiatric attention to enable a return to the original living situation and/or to give time to locate a new living situation.

Helping clients achieve greater independence through residential programs





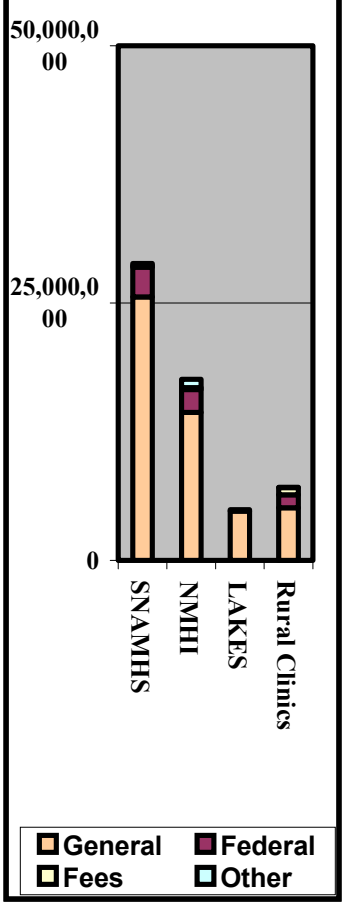
Specialized Residential - These programs provide support and/or skills training for residents with specialized service needs who also need psychiatric services. These programs include arrangements that are specially designed to meet the needs of the following individuals: people with medical problems, senior citizens requiring assistance, clients with severe behavioral symptoms, and deaf clients, as well as people needing treatment for substance abuse.

Programs for special populations:

Geriatric Services: These services are supported through grants from the Division of Aging Services and the Bureau of Alcohol and Drug Abuse to the Southern Nevada Adult Mental Health Services. People referred by the Division of Aging Services.

FUNDING SOURCES

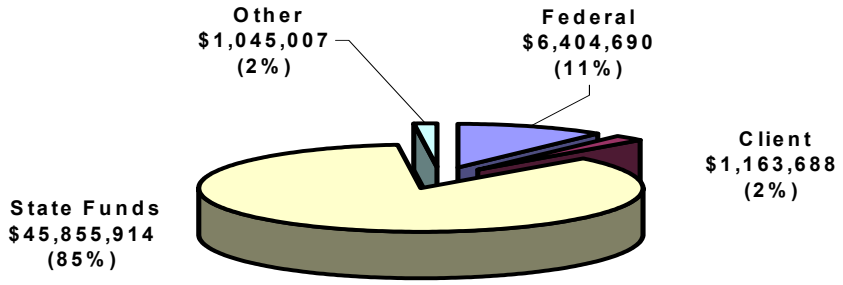
Figure 19. - FY00 Budget Expenditures



Mental Health Funding Sources and Expenditures

In fiscal year 2000, MHDS' operations cost $108,626,005. In fiscal year 2001 a total of $116,535,771 is budgeted for operations. Of this money, the majority (72%) of comes from Nevada's state general fund. Most of the remaining funds are Federal (24%) with revenue from client and other sources making up 4% of the total. Only 2% of the money is used for central administration. The mental health programs receive 52% of the money, budgeted at $60,516,836 in fiscal year 2001. **Fig. 19** and **Fig. 20** show funding sources and expenditures in Fiscal Year 2000 for Mental Health services.

Figure 20. MHDS Budgeted Mental Health Funding Sources: Fiscal Year 2000



Staffing to Meet Service Demands

Inpatient facilities are licensed and staffed to support a certain number of client beds. Other programs, such as personal service coordination (case management) have caseload standards or service level standards. When these are exceeded, waiting lists occur.

The Division was budgeted for 1166 staff positions in fiscal year 2000. Of these, 721 work for mental health agencies. **Figure 21** shows the distribution of staff in MHDS' mental health agencies. Sixty seven percent of these positions are employed in direct client care (see **Figure 22** – opposite page sidebar). If all programs are combined, there is one direct care staff for every 43 mental health clients. However, programs differ dramatically in the intensity of service and the staffing required to provide adequate service. The Lakes Crossing Center forensic facility has a ratio of one direct care

staff for every 3 clients. Inpatient facilities at SNAMHS and NMHI also have small client to staff ratios and serve clients around the clock. Intensive outpatient services have reduced clinical caseloads, such as one clinician or personal services coordinator (case manager) for every 15 clients. Other intensive outpatient services take a team approach to help clients reduce symptoms and develop self sufficiency. The ability to carry larger clinical or case management caseloads increases as clients become more independent and services focus more on life management needs than recovery from severe symptoms. Typically, case management caseloads are one personal services coordinator for every 35 clients. Many clients are maintained and function in a stable fashion in the community, only returning for medical services. Thus, nurses providing medical oversight at the medication clinics carry larger caseloads of one nurse to every 217 clients.

Measuring Effectiveness and Consumer Outcomes in Mental Health Programs

The ability for state public mental health programs to monitor and assure the quality of services through consumer oriented outcomes has been driven from the Federal level through a Presidential Task Force and programs and funding through the Center for Mental Health Services. By participating in organizations such as the National Association of State Mental Health Program Directors, Nevada has shared in this national effort.

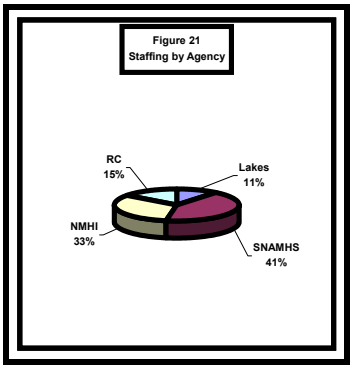
Support through the Mental Health Statistical Improvement Program (MHSIP) has been most beneficial This Federal program has provided grant funds that have assisted in the development of a statewide automated information system and mental health outcome measures here in Nevada. MHSIP has also provided the states with a model mental health "report card" that includes measures related to access to service, appropriateness of service, prevention and consumer outcomes. The MHSIP Report Card also includes survey instruments for evaluating clients' perception of care and satisfaction, as well as symptom reduction and improved functioning.

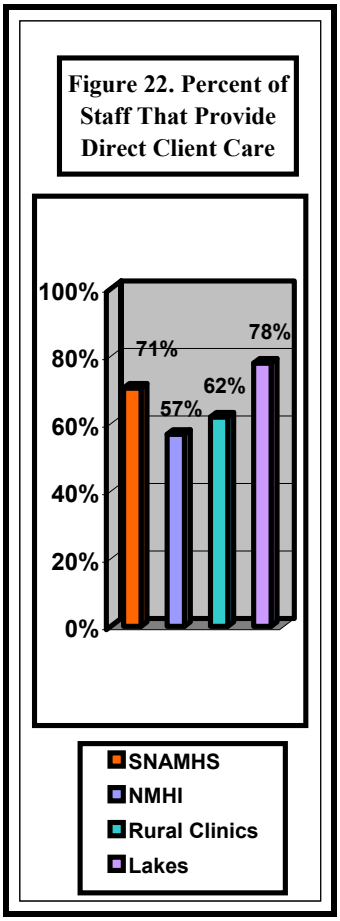
These outcome areas have been further defined in Nevada through a stakeholder values clarification project . Value areas that have been addressed in the development of consumer oriented outcome measures include: Skilled Coping, Personhood, Symptom Reduction, Functioning, Community Integration, Involvement in Treatment, Satisfaction, Family Support and Safety. [5]

Following are some examples of measures developed for evaluating these valued outcome areas. The data presented is from fiscal year 2000 for a variety of agencies, as indicated in each figure.

5 *Nevada Stakeholder's Priorities for Mental Health Outcomes*, McGuirk and Zahniser, 1996.

STAFFING PATTERNS





Mental Health Statistical Improvement Program – Federal Outcome Domains:

Access to Services

Appropriateness of Service

Prevention

Outcomes

Skilled coping, increased personhood, social functioning and community integration are evaluated with measures that look at increased community tenure, reduction in the number of hospitalizations, ability to enter and keep employment, ability to acquire and maintain a more independent living situation. **Figure 23** shows aspects of client ability to function in the community. Information, such as that shown, can be used to compare the effects of various programs on lengthening community tenure.

Access to services and continuity of care are evaluated with measures that look at the amount of time it takes between referral for service and actual service delivery as well as measures of whether the client keeps scheduled appointments and picks up prescribed medications. **Figure 24** illustrates the circumstances around missed appointments. This baseline information from SNAHMS will be useful in studying whether clients who are switched to the newer atypical medications are more likely to keep their appointments.

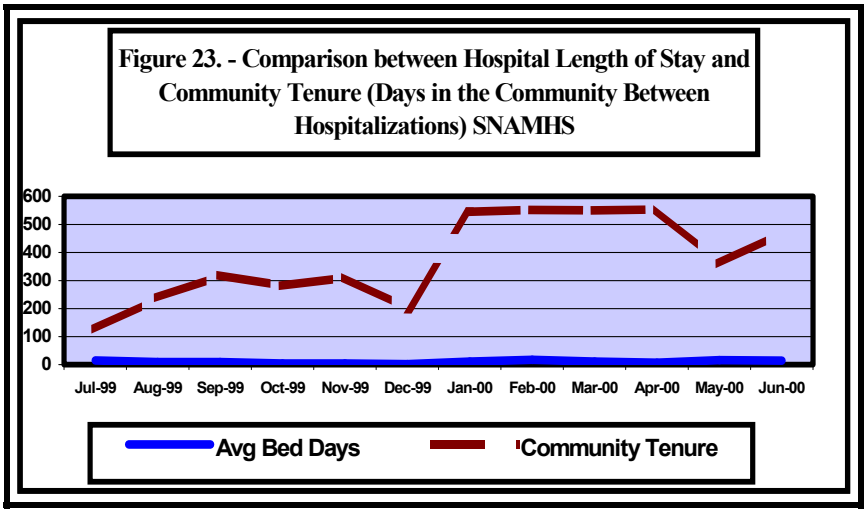
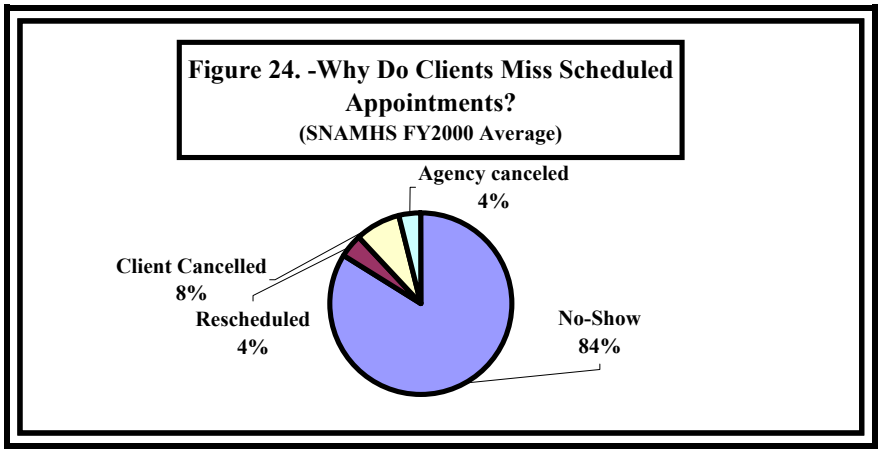


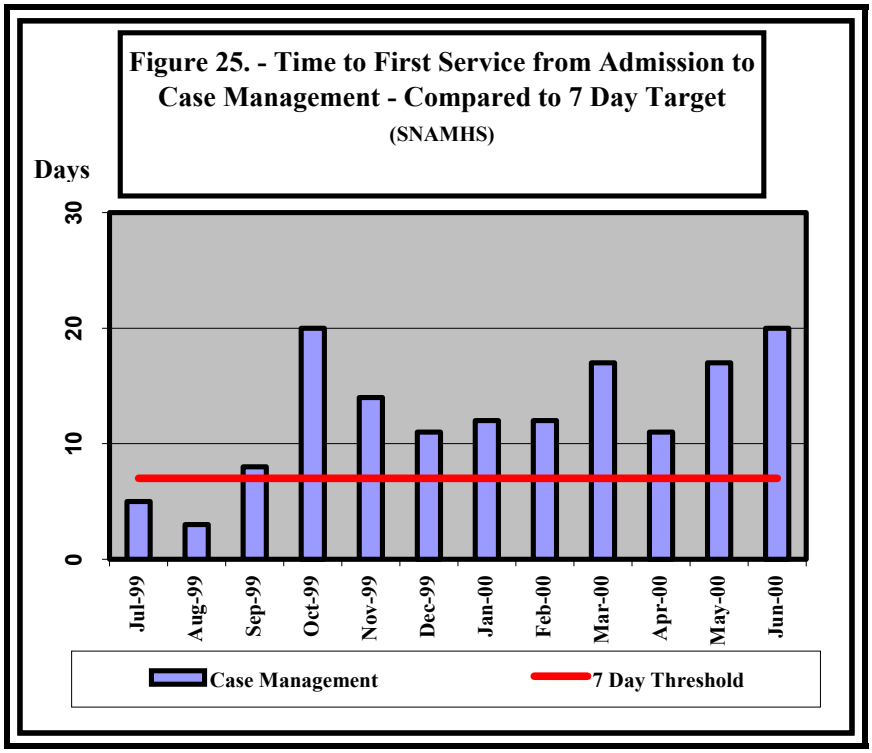
Figure 25 shows the average number of days after admission to case management before a client is seen for an appointment by a Personal Services Coordinator. Agencies attempt to meet a seven day service threshold. Policy dictates that all case management clients be seen every 30 days. While the average will peak above the Division's seven day target, it should never reach the 30 day policy threshold. Quality assurance activities are directed towards programs consistently beyond their seven day service target.

Measurements such as waiting lists or calculations comparing census or caseload levels to staffed levels show the ability of the agency to meet community demands for service. These measures indicate the ability to provide appropriate levels of service and indicate the need for additional resources to meet the demands of the community. Trends in inpatient census compared to capacity level can be used to predict a facility's ability to provide appropriate service in the future.

Quality of life is evaluated through surveys. To date, these efforts have been piloted for clients in Psychosocial Rehabilitation and clients who are making a switch from older to newer types of medication. Consumer satisfaction surveys are being administered by quality assurance staff.

Outcome measures and performance indicators are instrumental in planning for future services by helping predict program demand in the future. **Figure 26** shows the NMHI inpatient staffed level could be critically exceeded in the next biennium.





MENTAL HEALTH OUTCOMES

Nevada's Mental Health Stakeholder Outcome Domains:

Symptom Reduction

Improved Functioning

Skilled Coping

Personhood

Consumer Involvement in Treatment Plan

Community Integration

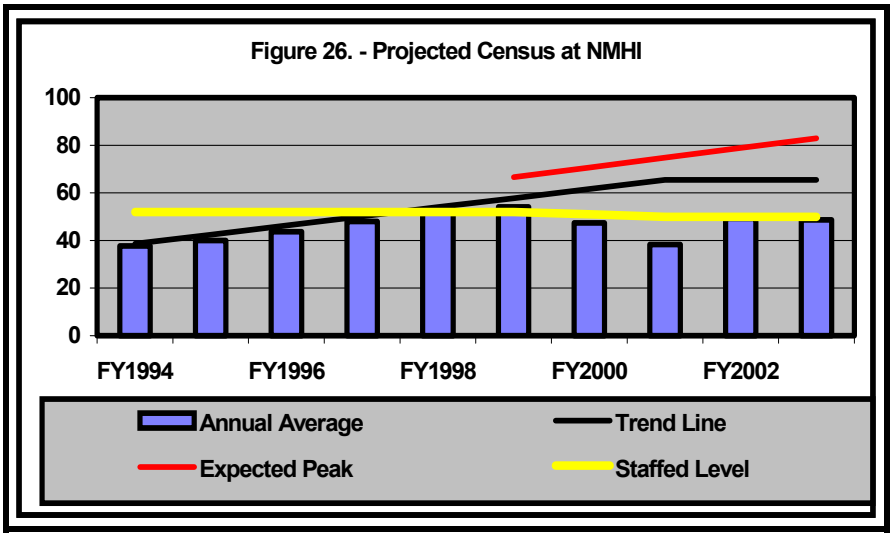
Social Functioning

Safety

Quality of Life

MENTAL HEALTH OUTCOMES

Outcome measures and performance indicators are instrumental in planning future services by helping predict program service demand



New Mental Health Budget Indicators

The development of new performance measures in Fiscal Year 1998 has allowed MHDS to use more meaningful indicators of service in the Fiscal Year 2000-2001 budget. New annual budget indicators include:

- Average length of stay in hospital;
- Percent readmission;
- Number of days in the community since last mental health hospitalization;
- Percent of time in community prior to program;
- Percent of time in community since admission to program;
- Percent decrease in hospitalization;
- Number of IP days prior to program (RTP);
- Number of IP days since admission to program (RTP);
- Average number of hospitalizations prior to program (RTP));
- Average number of hospitalizations since admission to program (RTP);
- Percent of time in the community prior to program (PACT);
- Percent of time in the community since admission to program;
- Active clients in job;
- Percentage of clients finding jobs within 90 days;
- Percentage of clients still employed after 90 days.

FISCAL YEAR 01-02 ACCOMPLISHMENTS

MENTAL HEALTH ACCOMPLISHMENTS

MENTAL HEALTH PROGRAMS - STATEWIDE PROJECTS

- Offered the "Nevada Exemplary Service Award" (NESA), which recognizes exemplary staff as part of the Division's Quality Assurance (QA) reviews. The MHDS Division QA staff have maintained a set schedule of on-site QA evaluations, and have expanded them to include at least one rural clinic, and both hospitals.
- The Division has completed a comprehensive Division wide MH disaster response plan. This plan has been utilized on at least three separate occasions since the plan was initially completed in June 2000. For example, the use of this plan has resulted in immediate and effective mental health services to Nevadans in emergencies in Dayton, Reno and an Alaska Airlines air disaster.
- The plan to use Mental Health Peer Counselors is now operational across Nevada.

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES (SNAMHS)

- Through the use of new medications and community based programs, SNAHMS is maintaining reduced hospitalization, length of stay, and hospital bed demand.
- Relocated and expanded the Sahara Avenue Clinic to better service the east Las Vegas area. Currently the average caseload is 150 clients at this clinic.
- Increased the number of clients entering and staying in employment and improving the quality of life for our clients and their families, from approximately 69 clients in FY98 to 83 in FY00.

NEVADA MENTAL HEALTH INSTITUTE (NHMI)

- Implemented the PACT program (Program for Assertive Community Treatment), which served an average of 33 seriously mentally ill citizens by providing therapeutic service in the community and not in the hospital.
- Implemented a 10-bed Psychiatric Emergency Service (PES) which provided crisis intervention, triage and referral services for an average of 368 citizens per month. The PES is designed to deflect clients from unnecessary admissions to the hospital to community-based services provided in their home setting.
- Renovated the two (2) inpatient wards and the outpatient clinic to provide patients a safer, cleaner and healthier environment in which to receive treatment.

MENTAL HEALTH ACCOMPLISHMENTS

RURAL CLINICS (RC)

- Improved accessibility and availability of mental health services in rural Nevada by providing services in Pahrump, redistributing positions within the Agency in accordance with changing populations (with no impact on state appropriations), and improving productivity.
- Obtaining input on community needs by developing stakeholders and advisory groups in each satellite area.
- Additional clients received specialized services of psychiatric nurses by reclassifying existing positions (no impact on state appropriations) and receiving alcohol and drug counseling through a grant from the Bureau of Alcohol and Drug Abuse.

LAKES CROSSING CENTER FOR THE MENTALLY DISORDERED OFFENDER (LCC)

- The 12-bed addition was completed making LCC a 48-bed facility. In addition to added beds, the new structure created more living space, added a new gymnasium and additional rooms for group therapy and activity therapy.
- The contract with Clark County Detention Center now provides multiple mental health services within the facility and the Las Vegas city jail. Those services are being reviewed for expansion and represent an excellent example of custodial and mental health services working together.
- Services continue at the Washoe County Detention Center and will be reviewed over the next biennium.

KEY LONG TERM OBJECTIVES

- The Division of MHDS provide and promote high quality and cost effectiveness services in a safe environment.
- The Division of MHDS will promote and support the least restrictive services possible in peoples' own communities, while reducing the Division's reliance on providing services through institutional placements.
- The Division of MHDS will ensure services address the interest, rights, and needs of each individual consumer.

SIGNIFICANT LEGISLATION

- NRS 433A.370, 433A.380 and 433A.390 were amended to allow for persons who have been involuntary committed to a mental health facility to be placed on convalescent or conditional leave for a period not to exceed 6 months. This change in the law is designed to allow for a client to be evaluated by staff and be re-hospitalized if necessary.
- State legislation passed by the 1999 State Legislature, authorizes judges to consider past mentally ill behavior when determining if an individual should be involuntary committed.
- State legislation, passed by the 1999 State Legislature, allows the Division to serve not only persons with mental retardation, but also persons with conditions related to mental retardation.

MENTAL HEALTH ACCOMPLISHMENTS

Challenge	*Plans for meeting the challenge*
Population Growth, especially in southern Nevada, has increased service demand requiring additional staff and resources.	Continue to evaluate and project the community's need for services. Budget for additional staff and resources to meet demands for programs showing the greatest need, such as medical services, psychiatric emergency care, services for the homeless.
Accreditation by the Joint Commission for Accreditation of Hospital Organizations (JCAHO)	Involve all levels of staff in planning and development. Re-engineer procedures as necessary.
Inpatient demand beyond staffing capacities	Put into operation, the 12 bed addition at Lakes Crossing Center. Invest in newer, state of the art medications that provide clients relief from mental health symptoms and reduce the demand for hospitalization.
Attract and maintain good personnel.	Based on analysis of staff turnover, conduct focus groups to highlight and improve areas that affect staff turnover.
Assure cost effectiveness, adequacy and quality of programs	Expand quality assurance program and continue to monitor programs using new consumer oriented outcome measures. Apply for additional federal funding to support the expansion of Nevada's outcome measurement program. Involve consumers and other stakeholders in the planning and quality assurance process.

DEVELOPMENTAL

SERVICES

Establish
partnerships
among stakeholders
as to the direction of
public mental health and
developmental services in the state.

Developmental Disabilities Stakeholder Values

Choices:
People choose personal goals and services. Choices include, but are not limited to, where to live and work and how to use free time.

People are Included in the Community:
People live and participate in the community interacting with other members and fulfilling different social roles.

Relationships:
People have friends and relationships and remain connected to their natural support network.

Rights:
People exercise their full rights as citizens and if their rights are limited they are afforded due process.

DEVELOPMENTAL SERVICES:

Involving Stakeholders

MISSION

It is the mission of each Regional Center to provide residential and community-based services for people in Nevada with developmental disabilities and related conditions. Agencies provide person-centered planning so that people can make choices about their lives, live in the least restrictive manner possible and live productively as part of the community.

PERSON CENTERED SYSTEM

The regional centers work in partnership with people who have developmental disabilities and their families to ensure they can select and direct meaningful services applicable to their principle goals, needs, and desires. Services are designed to maximize each person's independence, capabilities and satisfaction through a process referred to as person-centered planning.

Existing and available resources throughout the community are mobilized to ensure that support services are based on the value that all people with disabilities can and should decide for themselves what happens in their lives. The principles necessary to accomplish this begin with the person's desired future and focus on the person's abilities and capabilities.

DS has had a Service Vision for the Year 2000

Background:

During 2000 the Division participated with a variety of interested groups, consumers and persons to update and broaden service vision and goals.

Process of Including Stakeholders:

People served, families, boards, advisory groups, and service providers participated in regional meetings.
Our long range service vision continues to emphasize community based services.

SERVICE VISION 2000

The Service Vision includes six areas of service and defines specific goals for each area. They are:

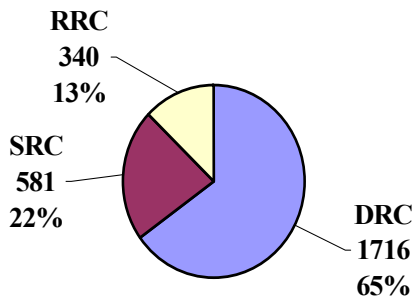
Service Accessibility

- Services will be available to 100% of eligible persons who request it. Nevada's growth continues to create a greater service need.

Service Coordination

- Provide service coordination to help all participants obtain individually chosen goals.

Fig. 27 NUMBER AND PERCENT OF PEOPLE SERVED BY REGION



Regional Centers

DRC - Desert Regional Center
SRC - Sierra Regional Center
RRC - Rural Regional Center

Mental Retardation Stakeholder Values

Dignity and Respect:
People are respected, have privacy, personal possessions, and choice about the sharing of personal information.

Health:
People have health care services adequate to achieve the best possible health.

Safety and Security:
People and safe, free from abuse and have economic security in their life.

Satisfaction:
People are satisfied with the services and assistance they receive in pursuing their goals.

DS GOALS

Service Accessibility

Service Coordination

Family Support

Jobs and Day Training

Residential Supports

Service Quality

Personal goals require defining the future and identifying and coordinating services that can be effective and efficient for goal attainment. Part of Service Coordination is to assure and enhance each individual's rights; including facilitating self-advocacy, providing personal advocacy, and supporting legal services for all persons based on individual need.

Family Support

- *Family support services will be provided on an ongoing basis to 100% of the families in need and based on individual needs.*
- *All residential care provided to children will be in community based settings. Nevada will develop in-state services for children.*

For normal development, children need to live in a family setting, not in an institution. Achievement will require a broader array of supports for families in their own community.

Jobs and Day Training

- *Of adults receiving day services, 100% will have a choice to work or train in an integrated setting in the community.*

The development of community-based job and day training supports is critical for increased work options, productivity, and community integration.

Residential Supports

- *Of people receiving residential supports, 100% will be living in chosen living arrangements to include their own home or six bed or smaller community settings. No more than 5% will be in State ICF/MR based settings.*
- *Supported living arrangements (SLA's) will be available to 75% of adults receiving residential assistance through Division Funds.*

These goals will mean greater individualized service choices. Achievement will require continued dispersal of large facilities and the creation of more supported living arrangements.

Service Quality

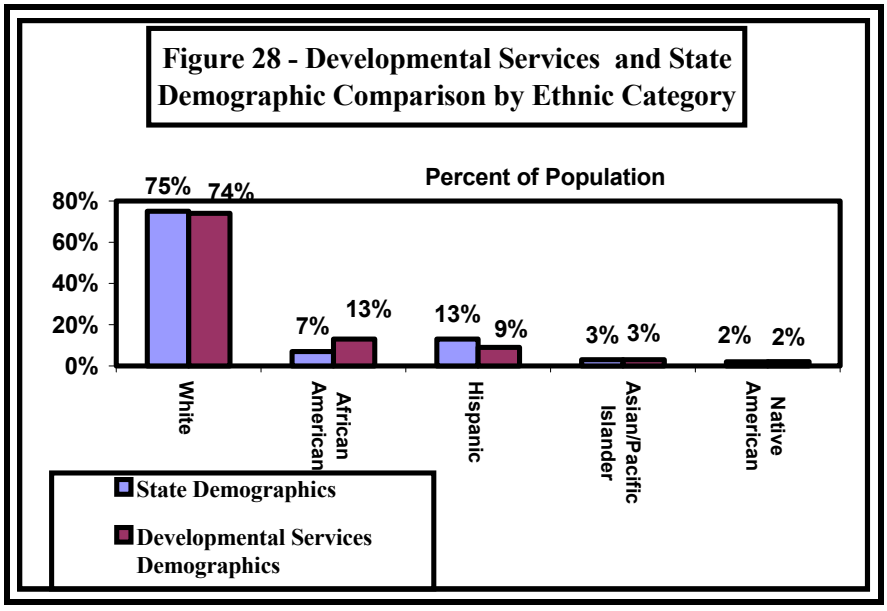
- *Services will achieve and maintain standards of The Council on Quality and Leadership in supports for people with disabilities (The Council – formerly the Accreditation Council).*

To assure high quality, services must meet independent, nationally recognized standards of care.

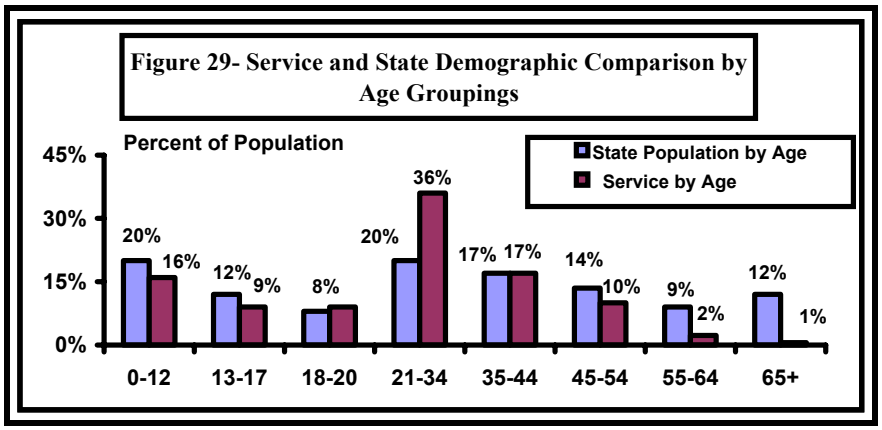
Who are the Recipients of Developmental Services

Fifty seven percent (57%) of the recipients of Developmental Services are male and 43% female. The ethnic composition is 74% White, 13% Black, 9% Hispanic, 2% American Indian and 3% Asian/Pacific Islander. Nevada's ethnic population characteristics are compared to DS's clients in **Figure 28.**

People receiving services consist of 25% children (aged 0-17)



and 75% adults (aged 18+). Clients are more likely to be in the age group from 21 to 34 years-old (36%). The elderly comprise 3% of the service population (55+). The Nevada general population is contrasted with the developmental service population in **Figure 29.**



Nevada's Demographics are Reflected in Persons Served

DS Mandate for Services

Nevada Legislative Intent

To charge the Division with recognizing its duty to act in the best interest of its clients by placing them in the least restrictive environment (NRS 433.003.2)

Federal Legislative Intent

…to assure that individuals with developmental disabilities and their families have access to culturally competent services, supports, and other assistance and opportunities that promote independence productivity, and integration and inclusion into the community

(The Developmental Disabilities Assistance and Bill of Rights Act Amendments of 2000

DEVELOPMENTAL SERVICES' PROGRAMS

SERVICE COORDINATION

All people who are eligible for services from a regional center are assigned a service coordinator (case manager). Service coordinators assist people in obtaining needed benefits and assessments. Through person-centered planning, the service coordinator works directly with the person (and others), helping the customer articulate his or her needs for the future. The service coordinator helps the person learn about and choose from available service providers and supports. Jointly, the customer and service coordinator develop service plans that focus on achieving consumer determined outcomes.

Service coordinators visit with the client at least quarterly to assess the efficacy of the plan and whether services are being provided as intended. Progress toward personal goals is assessed on an on-going basis. Plans may be updated and changed as the client's goals and needs for support change. At least annually, the service coordinator assesses the satisfaction of the consumer with the supports and services being received.

Service coordinators have a very important relationship with the client they work for. They are responsible for overseeing the quality of services and for making sure that the clients plan of care and treatment is implemented and changed as needed. People are encouraged to choose their own service coordinator.

FAMILY SUPPORT SERVICES

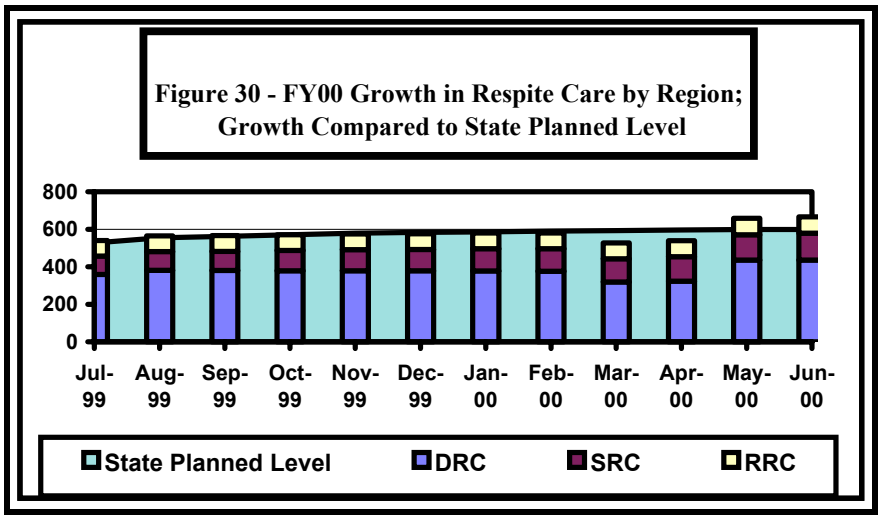
The Family Support Program was developed to assist families of individuals with developmental disabilities and related conditions to care for their relatives in their family home. All individuals who are eligible for services through Desert Regional, Sierra Regional, and Rural Regional Centers are eligible to apply for Family Support Services. The goal of the Family Support Program is to prevent costly out-of-home placement by assisting the family in caring for their relatives. Any charges for services are determined by using a sliding fee scale. Most consumers who are eligible for Medicaid pay no fees for services.

The Family Support Program provides the following services to consumers and their families:

1. Respite
2. Purchase of Service Supplements
3. Clinical Assessments
4. In-Home Training Services
5. Counseling
6. Family Preservation Programs

Respite provides temporary care in or out of the family home. Respite gives families a break from the day-to-day responsibilities of caring for their loved ones. Families receive respite vouchers to use at certified or licensed respite providers, in rural Nevada, or other providers of their choice. The amount of the voucher is based on the family's request, its financial co-pay (if any), and the available funding in the regional office. Families choose their respite providers and select the days and times when they want to use their vouchers. The respite provider charges the family any co-pay (if one is due) and then bills the remaining cost to the regional center after providing the respite services. Families may use their yearly allotments all at once for a vacation or in small monthly increments. The choice is up to the family. **Figure 30** shows growth in this program exceeding planned levels in Fiscal Year 2000.

Purchase of Service Supplements (POS) are provided to families to assist them with the excess costs of services for their relatives. All alternative funding sources and existing resources must be used by the family before the POS is issued to them. Families who request a POS must meet financial guidelines to receive vouchers from the DS agency. The POS is available to eligible families one time per year, for a maximum purchase of $300. The family can use the voucher with any vendor or provider that accepts it. The service/goods are provided to the family and the State Agency is billed for the service. Examples of items that can be purchased with the voucher include such things as:



- Medical/dental services not covered by insurance
- Special diets, clothing, special equipment
- Car seats, beds, special furnishings
- Recreation, leisure needs, respite
- Food, rent, utilities

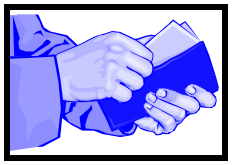
Studies have consistently shown higher quality of life in community settings.

Family Support Programs assist families of individuals with developmental disabilities to care for their family member at home

DEVELOPMENTAL SERVICES & PROGRAMS

Clinical Assessments help an agency team develop training programs with the client

Family Preservation provides monthly cash assistance to low-income families caring for relatives with severe or profound develop-mental disabilities



Clinical Assessments are available for consumers who are in need of assessments or evaluations by a social worker, psychologist, or nurse. The assessments provide information that can be used to assist the individual's treatment planning team to develop training programs, and help the person gain services, obtain a job, move to a community residential program, etc. A sliding fee scale is used to determine if the individual is responsible for any costs. Medicaid and private insurance companies will be billed for the covered individuals who use the service. Families who are uninsured or who are unable to pay for the services will not be required to do so when funding is available through the DS agency.

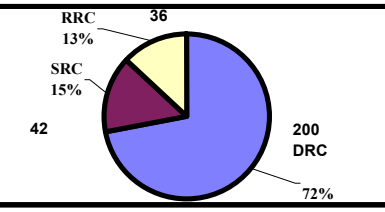
In-Home Training is available to consumers and their families who request assistance in their home with teaching skills that can help the family to cope better with their relative's special needs. The in-home trainer can work with individuals and their families in such areas as personal care, meal preparation, safety and leisure skills, transportation, behavior management, etc. The family identifies the training needs with assistance from the service coordinator. Training can be provided on a short or long term basis depending on the person's needs and the availability of funding in the DS agency.

Counseling is available to individuals and their family members to provide support and guidance in problem solving. Many different areas of need can be addressed with counseling services including; personal independence, self-esteem, community participation, social-sexual issues, work issues, etc. The individual and/or the family can choose the counselor and most services can be billed to Medicaid or private insurance. A co-pay maybe charged if the person is able to contribute to the cost.

The Family Preservation Programs provides cash assistance to low-income families caring for their relatives with severe or profound developmental disabilities in the family home. The financial assistance can be used for a variety of needed services (supplies, equipment, transportation, general income supplement). The monthly allotment may vary from family to family and is determined by using a sliding fee scale and the available funding in the state budget. **Figure 31** shows program agency caseload percentages for this program.

Any individual or their family member who wants to apply for Family Support Programs should contact their service coordinator (case manager) for more information or local DS agency to open a case for services.

Figure 31 - FY00 Family Preservation Program: Average Caseload by Region



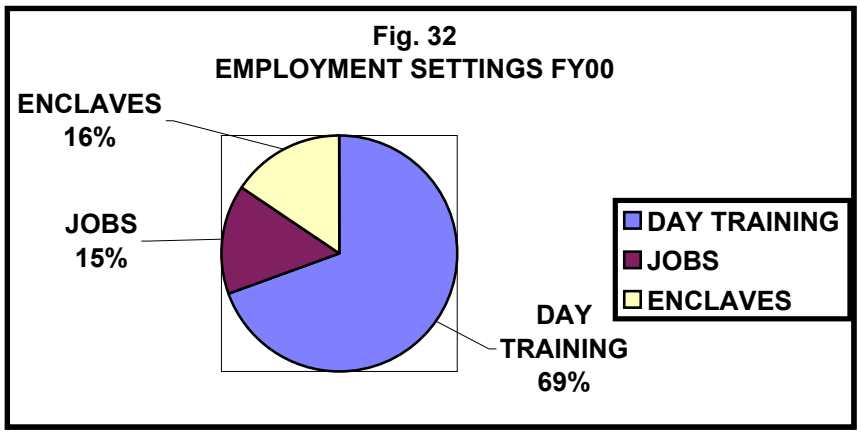
JOB AND DAY TRAINING PROGRAMS

All adults who are eligible for services from Desert Regional Center, Sierra Regional Center, or Rural Regional Center are eligible for Jobs and Day Training Services. These services vary in the type and intensity of supports to allow individuals vocational choices. Supports range from pre-vocational and vocational training in supervised, structure settings, to enclaves (supervised work groups in community job setting), to supported employment, including activities needed to sustain paid competitive employment or follow-along services. Regional Centers contract with private, nonprofit organizations that operate Community Training Centers and other qualified providers that offer training choices to consumers based on their interests and skill levels.

Job Services are available to consumers who need assistance to secure and maintain jobs in the community. Regional Centers contract with various private agencies as well as work cooperatively with the Bureau of Vocational Rehabilitation to provide work skill assessments, job development, job training, and follow along services through job coaching.

Community Based Work Groups (ENCLAVES) provide individual's vocational opportunities in the community and the opportunity to acquire the necessary skills that will assist them in sustaining employment in the community. It enhances their understanding of the community in which they live and the opportunities that are available to them. It also allows individuals to work outside of the facility based environment (workshop) without being required to meet the industrial standards of the job. Individuals with the supervision of a staff member are placed at a job site in the community. The staff member is present to offer support and help should it be needed. Most enclaves are part time. Currently, statewide enclaves are performing work at many local businesses: (food services, manufacturing, building and grounds, service industries and janitorial services).

Fig. 32
EMPLOYMENT SETTINGS FY00



Job and Day Training Programs

Residential Programs provide alternatives to more expensive and restrictive Institutional settings.

Day Training Services are available through Community Training Centers (CTCs) and other qualified providers. Day training is designed to provide vocational experiences for people who need more intensive personal or behavioral supports or to assist individuals to learn skills necessary for success in a job.
Figure 32 (previous page**)** shows employment settings for the three programs.

RESIDENTIAL SUPPORTS

Residential Supports are available to people who require assistance . All individuals who have open cases with Desert Regional Center, Sierra Regional Center, or Rural Regional Center may request residential supports. This program is designed with a goal of allowing people to live in a home of their choice as self-sufficiently as possible. Most people prefer their own home rather than institutional care. These are important alternatives to restrictive and costly institutional settings.

Residential services are funded by using the individual's own resources (Social Security benefits, job income, etc.) and supplementing these as needed with state and federal funds. The Nevada Medicaid Program funds the costs of many support services if the individual is eligible. The State also provides funds to assist the person with expenses of living in the community.

The following residential options are available:

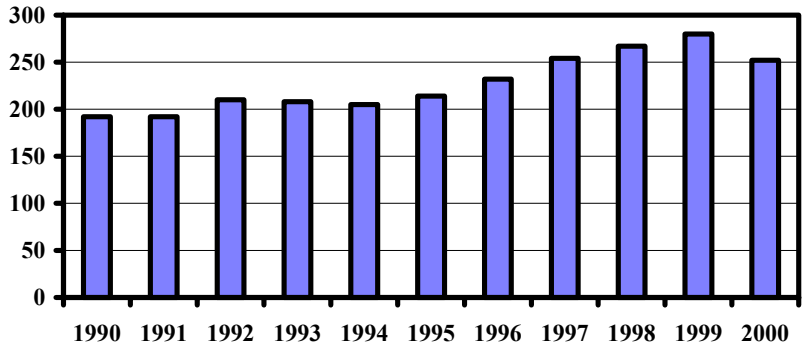
1. Intermediate Care Facilities for people with mental retardation and related conditions. (ICFs/MR)
    a. State ICFs/MR
    b. Small Private ICFs/MR
2. Intensive Supported Living Arrangements
3. Supported Living Arrangements
4. Private Group Homes
5. Developmental Homes

State ICFs/MR provide twenty-four hour supervision and training to individuals who require intensive support, medical care, treatment, and training. Located at Desert Regional Center or Sierra Regional Center, these campus-based homes are licensed to provide services to approximately 166 people. The homes house from four to twelve people. Each facility is staffed by state employees on a 24-hour basis and must follow strict Federal and State guidelines. The programs are funded by Nevada Medicaid, and offer specialized services . This setting is also the most restrictive. **Figure 33** (next page) shows the number of people per year in all the programs.

Small Private ICFs/MR provide residential services in small community residences for up to six people. The individuals who require this level of care need intense treatment and training but live in community neighborhood houses with 24-hour awake supervision and support. The services are provided by private organizations (or the state) and are funded by the Medicaid Program. The same Federal

and State guidelines as guide larger ICFs/MR guide these homes. The services provided in an ICF/MR Small are considered less restrictive than the ICF/MR services provided in large State run facilities because they are located in community neighborhoods.

Figure 33. Developmental Services Clients Living in ICFs/MR



Intensive Supported Living Arrangements (ISLAs) provide services in community residences for up to four individuals who live in their own homes. The services are provided by private organizations. These services were developed as an alternative to ICF/MR so that individuals could live in the community while receiving intensive support and training. Individuals who choose ISLAs must be capable of contributing to the costs of their services, and may have intense medical or behavioral training/treatment needs. 24 hour supervision is provided .

Supported Living Arrangements (SLAs) are individualized living supports that supplement individuals' resources in their own homes. Assistance is designed to help persons achieve and maintain maximum independence in the community. Supports are contracted with private providers. Support staff visit the individual on an individualized schedule that depends on a person's needs and preferences. The services are paid for by the individual and may be subsidized by the State Agency and/or Nevada Medicaid. This is the most self-determined level of support for individuals and considered the least restrictive support option for adults. Because of this, SLAs are a preferred program (See **Figures 34 and 35** next page).

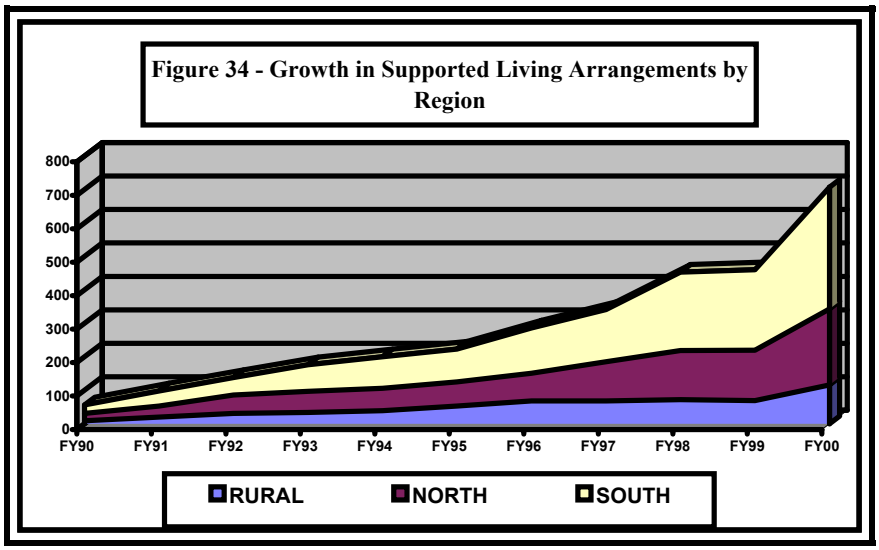
Private Group Homes are located in community neighborhoods and serve up to six individuals. The services are provided by private organizations. The homes are certified by the DS agency. They are able to serve individuals who are age 18 years or older and need some support and training. There is no awake staff at night and individuals may have intermittent periods unsupervised if their treatment team approves it.

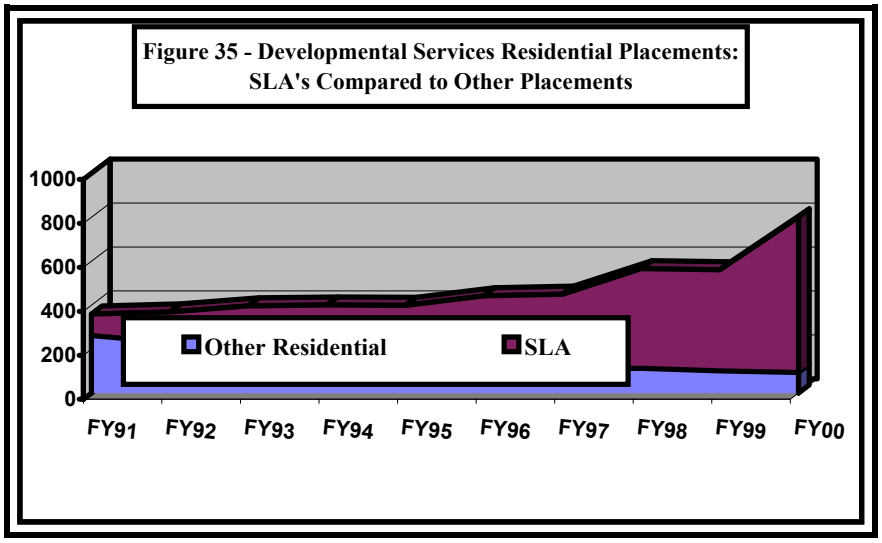
Supported Living Arrangements

Individualized living supports that supplement individuals' resources in their own homes. Helping persons achieve independence in the community.

DEVELOPMENTAL SERVICES & PROGRAMS

Growth in the SLA program reflects DS's goal of placing clients in the least restrictive environment possible



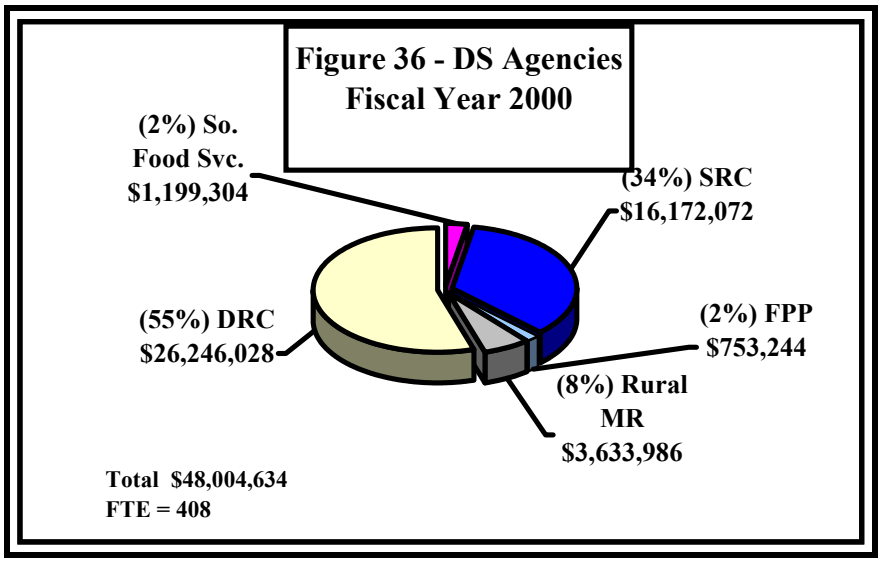


Developmental Homes are private homes in the community that typically serve up to four individuals who are usually younger or more dependent individuals who desire or need a more "family" type of living situation. The providers are private people who choose to have their homes licensed and/or certified to care for individuals with mental retardation and related conditions. The people who live in these homes are included in all the provider family's life and activities.

DEVELOPMENTAL SERVICES FUNDING SOURCES AND EXPENDITURES

Funding for Developmental Services agencies for fiscal year 2000 was $48,004,634. The allocation of funding by the DS agency is presented in **Figure 36**. This includes the allocation for the Family Preservation Program (FPP).

Revenue sources for Developmental Services are comprised of three main sources: State General Fund (57.88%), Federal (43.96%) and fee, charges and other sources (4.63%). Most of the federal funds represent the federal share of Medicaid (50% State share, 50% Federal share). Eligible Medicaid services are ICF/MR and community services through the Medicaid Home and Community Based (HCBS) Waiver. **Figure 36** shows the planned expenditures for the various DS budgets in Fiscal Year 2000.



STAFFING TO MEET SERVICE DEMANDS

Background

During the 1997 and 1999 session, the Legislature expressed concern about growing waiting lists for developmental services. At their request the administration developed, and the Legislature approved, a plan to address current and projected waiting lists. The plan funded service growth evenly over the course of the biennium. The plan is intended to fund anticipated family and community based services such as family support, respite, case management, and jobs and day training such as provided through the Community Training Centers [CTCs]. The plan also converted some ICF/MR placements to community living. The Medicaid Home and Community Based Services Waiver [HCBS] provides federal match for most of the services.

Service Levels are planned in order to respond to current and projected waiting lists

DEVELOPMENTAL SERVICES WAITING LISTS

Waiting Lists are a key indicator of ability to meet public need for services.

Waiting Lists FY 2000:

Waiting lists decreased by the end of FY00, along with large increases in new cases.

Total Regional Caseload)
Statewide, the waiting list decreased from 262 in June FY98 to 151 in June FY00. This represents a reduction of 42% in the waiting list. During the same time the total statewide caseload grew from 2010 cases in July FY98 to 2637 cases in June of FY00. This was an increase of 627 new cases or an increase of 31%.

Day Training - The waiting list decreased from 81 in July FY98 to 58 in July FY00.

Jobs - In June of FY00, the job placement waiting list was 45. Over the last two years many individuals have found job placements in private sector enclaves.

Residential Waiting Lists - Residential waiting lists increased from 164 in July FY98 to 189 in June FY00. This is an overall increase of 25 or 15%. This does not reflect the planned and funded growth the Division is phasing in services and will fund 117 more support placements by the end of FY01. While waiting lists in ICF/MR institutional settings have greatly decreased, waiting lists for community placements have increased despite the huge growth in new placements. The number of placements in Supported Living Arrangements grew from 453 in June FY98 to 707 in June of FY00. This is an increase of 254 new placements or a growth of 56%.

Respite - The respite program has not had a waiting list in the past, since all persons are enrolled and the available resources are spread amongst them. Families enrolled in the respite program have increased from 495 in June FY98 to 666 in June of FY00. This growth of 171 families represents a 35% increase. This exceeds the funded level of 599 families and has resulted in the beginning of a waiting list for new recipients in the Las Vegas area to avoid excess dilution of services to current cases. As the number of families increase, family respite allotments may be reduced.

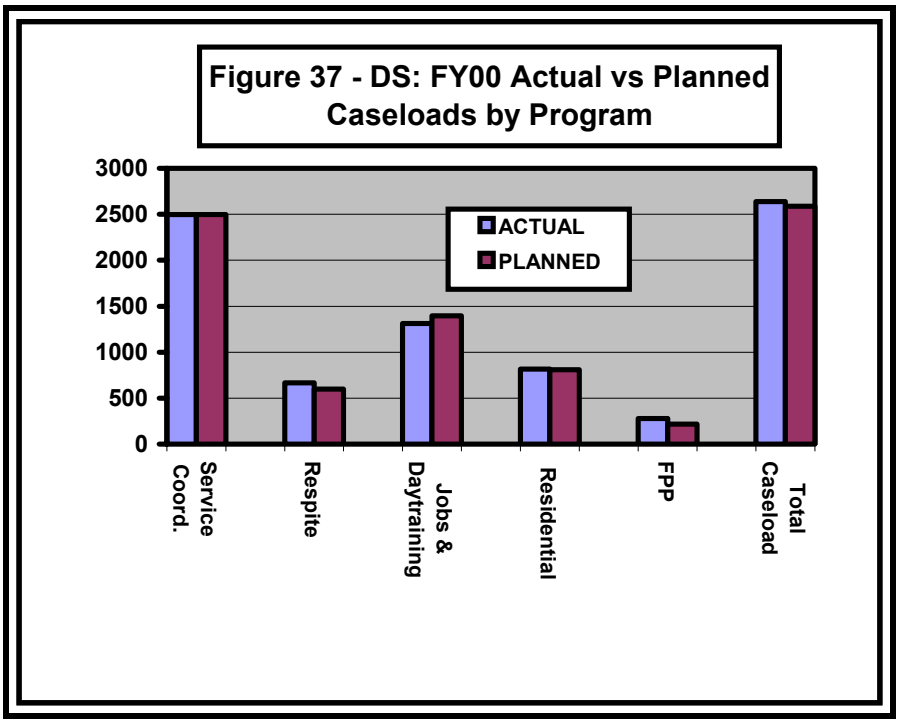
Family Preservation Program - The Family Preservation Program, which was expanded to cover persons with severe as well as profound developmental disabilities, increased from 187 recipients in July of 1998 to 278 in July of 2000. This was an increase of 91 families served or 49%.

Residential Outcomes - Agencies continue to progress at converting to community and individualized services. In June of FY00, 86% of all people receiving residential support lived in community settings of 6 or fewer individuals. This is a 5% increase from 81% average in June of FY 98. In addition, 88% of persons in community living [Category 11] are receiving individualized service plans as driven by a Supported Living Arrangement contract. This is an increase of 8% from the 80% average in FY 98.

Summary

Developmental Services has grown considerably over the last three years. Overall, Developmental Services reduced the total caseload waiting list by 42% while the caseload grew by 627 new cases or 31%. As of June FY00, the waiting list represents less than 6% of the total caseload of 2,637. High demand exists for service coordination, family supports, and residential supports. The requirement to serve persons with related conditions has added over 200 new cases to the service delivery system. Service targets continue to be met while waiting lists have been significantly reduced. **Figure 37** shows attainment of planned levels in Fiscal Year 2000.
Figure 38 displays the growth in caseload and remaining waiting list

High demand exists for service coordination, family respite, and residential placement programs.



DS OUTCOME MEASURES

PERSONAL OUTCOME MEASURES

AUTONOMY

People choose their daily routine.

People have time, space, and opportunity for privacy.

People decide to share personal information. People use their environments.

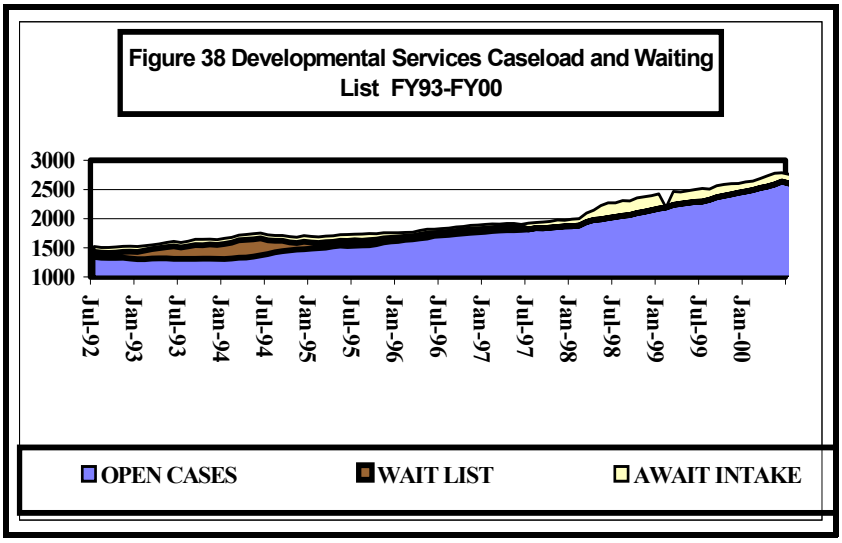
HEALTH AND WELLNESS

People have the best possible health.

People are free from abuse and neglect.

People experience continuity and security.

over the last seven years. DS continues to phase in newly funded services. This will continue through FY01.



MEASURING EFFECTIVENESS AND CONSUMER OUTCOMES IN DEVELOPMENTAL SERVICES PROGRAMS

Developmental Services within the Division of Mental Health and Developmental Services collects outcome information on a monthly basis. A variety of measures are collected that are applicable at individual, program, regional, and statewide levels. This information is used to track progress and identifies areas for improvement.

Customer Based Outcomes and Satisfaction

In order to continually assess services, personal outcomes for persons served are captured through extended individual interviews with the person and people who know them best. Interviews are based on national accreditation standards and measure service values such as dignity, choice, relationships, health, rights, satisfaction and community inclusion. These are the same values as defined in State, Federal Legislation and in Position Papers of the National Association of Retarded Citizens.

Interviews are conducted using interviewers who are trained by The Council on Quality and Leadership in Supports for People with Disabilities (The Council). Interviewers use *The Council's Personal Outcome Measures*, a process that is used by The Council nationwide to determine accreditation for agencies providing services to people with disabilities. The 25 Personal Outcome Measures provide the means to determine if agencies are providing the supports and services that people receiving services expect and that that are

effectively in helping them reach their desired life outcomes. The Division contracts with the University of Nevada, University Affiliated Program (Department of Education, UNR) to provide independent interviews throughout the state. The University of Nevada, Las Vegas faculty and students participate in Clark County, while the University of Nevada, Reno faculty and students conduct the interviews in Washoe County and outlying rural areas. On-going findings provide feedback to each individual's planning team and support staff, as well as to programs, regional agencies, and statewide levels. Because the focus of services is on supporting people to achieve their individually-defined personal outcomes, information provided by this project is invaluable in the development of each agency's internal goals and objectives and for strategic planning. A Biennial Legislative Report is also provided.

Community Inclusion and Individualization as Outcome Measures

Based on the goal of providing people services that will support people to achieve their personal goals in the least restrictive environment possible, indicators can be derived by determining (1) the number and percentage of people living in their own homes in the community, (2) the number and percentage of people who have individualized living arrangements, and (3) the average number of persons per residential setting. Each of these measures reflects the degree of choice and individualization of services. These proxy measures can be viewed as approximate measures of the desirable values. Studies have consistently shown higher quality of life in community settings. Conversely, the number and percent of people in institutions identifies people who are served in the most restrictive environments. Several states have abandoned the use of large institutional settings. This has usually been when states with large institutions are targets of class action lawsuits.

Maximum independence is an additional goal for persons with mental retardation and related conditions. While many people will not gain total independence and will require some type of lifelong supports , each person is encouraged to be as self sufficient as possible. A measure of this is the number of customers who are placed in actual competitive jobs and the average income earned through work.

These system level measures are reported as performance indicators during the budgeting and legislative process. Care has been taken to coordinate with national databases that can be used to benchmark Nevada with other states.

Other Outcomes

In addition to system outcomes described above, component programs such as service coordination (case management), family support, jobs and day training, and residential support have identified outcomes that track progress.

DS OUTCOME MEASURES

PERSONAL OUTCOME MEASURES

IDENTITY

People choose personal goals.

People choose where and with whom they live.

People choose where they work.

People have intimate relationships.

People are satisfied with services.

People are satisfied with their personal life situations.

RIGHTS

People exercise rights.

People are treated fairly.

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PERSONAL OUTCOME MEASURES

IDENTITY

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The outcome evaluation system in Developmental Services programs is designed to provide information that supports decision-making at all levels, from policy to individual service decisions. The intent is to track information that reflects important service results for people served and provides a basis for decision-making that is in the best interest of stakeholders. In other words, the goal is to provide the best possible service to people with mental retardation and related conditions and the tax payers of Nevada.

Accomplishments in Developmental Services - FY 2000

New Service Population: People with Related Conditions.
The expansion of the criteria for eligibility for Developmental Services to include conditions related to mental retardation, such as autism, cerebral palsy, epilepsy, etc. allowed many people with developmental disabilities and their families to receive assistance from MHDS who previously had no access to needed services. This service population currently represents 8% of the total caseload. All regions added staff to speed up the application process.

Accreditation Process Improves Quality of Services.
Developmental Services continued to work toward Accreditation for services. Desert Regional Center currently has a two year accreditation while Rural Regional center and Sierra Regional Center prepare for reviews. With feedback through interviews conducted by the University Affiliated Project (Department of Education, UNR), regional services have focused on improving the quality of supports related to personal outcomes of persons receiving services.

Expanded Home and Community-Based Waiver Assists Families.
The expanded waiver program provided additional Family Support and Jobs and Day Training Services through access to Medicaid funding. The Waiver program increased available federal revenues for needed services such as respite, in-home training, counseling, in-home supported living, and vocational training.

Converted ICF/MR State run Programs to Community Living Options.
Developmental Services in the South converted 6 beds to provide community-based intensive supports. Sierra Regional Center converted 12 beds.

Supported Living Arrangements (SLAs) Continue to Grow: 1990 to Present.
The supported living arrangement program has grown over the past ten years to provide personalized community living to 707 persons

who would otherwise require more restrictive and costly care. This individualization of services did not exist in Nevada until the 1990's. Expanded SLA supports have allowed many people to move from ICF/MR programs to their own homes in the community. Of the 707 SLA's in the community, over 200 provide 24 hour care.

Improved Access to Developmental Services.
Service offices have been added in Winnemucca and Las Vegas. New satellite offices provide better local access for service coordination. All regions have added staff to speed up the application process.

Family Supports Broadened to Help People Remain in Their Natural Homes.
Developmental Services provides expanded family support services to over 1,000 families a month. This includes respite services as well as purchase of services, counseling, and screenings. In-home training and in-home supported living services diverted people from waiting lists for out-of-home placement. Direct financial assistance (Family Preservation Program) has been expanded to cover additional families who care for a family member at home.

Service Coordination improved accessibility.
The regions have added 1,266 cases to services since 1994 (this represents an overall increase of caseload growth of 92% over 6 years) so that total services reach over 2600 individuals and families stateside. By the end of FY01 the total service population will approach 3000. DS continues efforts to reduce waiting lists which decreased from 256 in June FY98 to 151 by June FY00. Also intake assessment times have been greatly reduced.

Jobs in the Community Promote Productivity and Integration.
While the state funded jobs program served 188 persons, a special jobs survey in FY00 indicated that 241 persons were working enclaves (private settings in the community). Together, currently 475 have integrated employment settings. This employment option attracted people because of the high average wages paid (over $6 per hour verses $2 to $3 per hour earned in non-private settings.

DS FY 2000 ACCOMPLISHMENTS

Greater availability of service through new eligibility definition

Improved Access to Services.

Improving quality of service through the Accreditation process

Broadening and Strengthening of Programs.

Service Coordination addressing waiting lists

DS FY 2000 CHALLENGES

Challenge	*Plans for meeting the challenge*
POPULATION GROWTH IS A CHALLENGE FOR NEVADA. Nevada's growth especially in southern Nevada creates increased demand for services for people with mental retardation and related conditions. Waiting lists for services are a reality throughout the state. In particular, residential waiting lists continue to challenge our services. Payments and support for families are being reduced to accommodate increasing requests for services, (i.e. Respite and Family Preservation Programs).	Budget for growth through analysis of service demands in Nevada. Develop infrastructure to deliver the services. Emphasize cost effective programs such as service coordination, supporting families, and community living. Maximize federal participation through the Medicaid Home and Community-Based Services-Waiver (HCBS) and TANF funds to help defray the costs of services. Continue to identify people with conditions related to mental retardation and develop baseline of occurrence for Nevada
SOME CHILDREN WITH DISABILITIES CONTINUE TO LIVE IN INSTITUTIONAL SETTINGS OR ARE SERVED OUT-OF-STATE. Many children who require intensive supports due to medical and/or behavioral needs continue to live in ICF/MR facilities, both in Nevada and out-of-state. All children, regardless of their level of disability, should be served either in their natural homes with sufficient assistance to the family or in therapeutic foster homes to stop the cycle of institutionalization	Increase availability of Family support services (respite) and Family Preservation payments to families to re-unify and maintain families with children who have intensive support needs. Work with providers to develop additional residential options for children.

Challenge	*Plans for meeting the challenge*
CONTINUE TO IMPROVE ACCESS, CHOICE AND PERSON DRIVEN SERVICES.	Continue to work in partnership with providers and stakeholders to identify and increase the range and quality of services based on consumer goals. Recruit providers in rural communities, such as Pahrump, Ely, and Tonopah, among others, to enable people to receive individualized services in their own communities. Continue and expand program evaluation feedback of services and outcomes using national standards as benchmarks.
ASSURE CONTINUING QUALITY IMPROVEMENT AND COST EFFECTIVENESS. Assure that services are cost effective and maintain a focus of attaining personal outcomes with the best use of resources.	Develop ways for persons to better direct their own services. Provide person centered and driven services for all individuals. Budget for and support training of staff and providers to improve quality. Pursue the strict standards of The Council (formerly the Accreditation Council), a private organization that accredits mental retardation agencies. Increase accredited services to 100% coverage from the current 63%.

Special Thanks

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Troy Williams, Producer **2/23/00**